

066139 SEP 19 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA GAYLE ADAMS									
20. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14 1987		2b. HOUR 602 AM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 22, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7b. HOUR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY BALTO		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4122 Townsend Ave. Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST Lize ----- Gillum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malinda ----- Sexton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 402-05-4299D		17. INFORMANT 21061 ADDRESS Glen Burnie, Md. Joan A. Woolsoncroft, 602 Pamela Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe coronary artery disease old</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes with Blindness and Peripheral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>neutritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		22c. DEGREE DEGREE		22d. DATE SIGNED 9/14/87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BALJIT S. SAHNEY M.D.		22f. ADDRESS 7422 BALTIMORE ANNAPOLIS BOULEVAR							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent.		23d. LOCATION BALTO. A.A. Co. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave.		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

DHMH-16 50M 1/81
(VRA 15, 4)

000130 SEP 19 87



064934 SEP-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4812

1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		2c. HOUR	
Reed m.B. Adams		9 2 87		7:43pm	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
male	White	3 24 02		85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia	USA			AA Co. MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Annap.	Anne Arundel General Hospital		Lt. Commander		NAVY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS?	13f. STREET ADDRESS / ZIP CODE
md.	A.A.	Annap.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	18. W. Linden Ave. 21401
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Anchie Lyle Adams	Effie Letitia Updegraff		YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE YEAR OR DATES)		
16b. SOCIAL SECURITY NO.		17. INFORMANT			
216-32-5352		Ethlynn P.W. Adams - #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) BRAIN ANOXIA					3-51
DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE (R) Intracerebral Bleed					12-24H
DUE TO, OR AS A CONSEQUENCE OF (c) L4L5 septic diskitis					2-3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Sick Sinus Syndrome, Renal Failure, Gram Negative, positive Sepsis, Anemia, CAD					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 8/17, 1987, to 9/2, 1987, that (we) lost saw the deceased alive on 9/2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Andrew Gordon MD		MD			9/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Andrew Gordon MD		16 Murray Ave Annapolis, Md 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremated	Sept 5, 1987	Cedar Hill	Suitland PG. MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel - Annapolis MD		SEPO4 1987		[Signature]	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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066375 SEP 22 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24813
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Thelma</u> MIDDLE: LAST: <u>ADAMS</u>			2a. DATE OF DEATH MONTH: <u>August</u> DAY: <u>24</u> YEAR: <u>1987</u>		2b. HOUR <u>10⁵⁰ PM</u>						
3. SEX <u>Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH: <u>8</u> DAY: <u>5</u> YEAR: <u>1911</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.		IF UNDER 24 HRS HOURS: MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD.					
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>A.A.</u>		13c. CITY OR TOWN <u>ANNAPOLIS</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>920 Central Avenue 21401</u>			
14. FATHER'S NAME FIRST: <u>JOHNNIE</u> MIDDLE: LAST: <u>JOHNSON</u>				15. MOTHER'S MAIDEN NAME FIRST: <u>ELIZABETH</u> MIDDLE: LAST: <u>JOHNSON</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219-05-1008</u>		17. INFORMANT <u>GOLDIE GROOMS</u>		ADDRESS <u>Annapolis, Md. 21401</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction, right hemisphere</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral embolus</u> <u>1 day</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary heart disease</u> <u>chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Distal small bowel obstruction - probably due to embolus</u>											
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 5</u> 19 <u>82</u> , to <u>Aug 24</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>August 24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles W. Kinzer</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>Aug 25, 1987</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHARLES W. KINZER MD</u>				22e. ADDRESS <u>ANNAPOLIS, MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8-31-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINELAWN MEM. PARK</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis A.A. Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>WILLIAM REESE & SONS MORTUARY, P.A.</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 14 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Swenson-Rudace</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified alone.

BP

John

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 1067417 1067417		2. DECEASED NAME (TYPE OR PRINT) Robert B. Anderson Jr.		3. FIRST MIDDLE LAST		4. DATE OF DEATH MONTH DAY YEAR 24 8 1987		5. HOUR M	
6. SEX male		7. RACE white		8. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1900		9. AGE (IN YEARS LAST BIRTHDAY) 87		10. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA		13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		14. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
16. CITY OR TOWN OF DEATH Annapolis		17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center		18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Annapolis		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS / ZIP CODE 700 Van Buren Street 21403	
21. FATHER'S NAME FIRST MIDDLE LAST Robert B. Anderson, Sr.		22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Halversen		23. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WWII		24. SOCIAL SECURITY NO. 220-34-8924		25. INFORMANT Robert Von Mehren New York, NY 10022	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN ANOXIA DUE TO, OR AS A CONSEQUENCE OF (b) CARDIO RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SYNDROME									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recurrent TIA's, Senile Dementia, Malnutrition.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF OPERATION		21h. CONDITION FOR WHICH OPERATION WAS PERFORMED		21i. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21j. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. I certify that (if this hospital) attended the deceased from 9/22/87, 19 87, to 9/27/87, 19 87, that (we) last saw the deceased alive on 9/27/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (b) (c) (d) did not view the body after death.									
22b. SIGNATURE Andrew Gordon MD		22c. DATE SIGNED SEPT 27, 87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW GORDON MD		22e. ADDRESS 16 Murray Ave Annapolis Md 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/30/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AD MD			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		24b. ADDRESS 1067417		25a. DATE REC'D. BY REGISTRAR OCT 1 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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8-87^{RE}
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24815
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George E. Akehurst Jr			2a. DATE OF DEATH MONTH DAY YEAR September 1 1987			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 15 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 664 Riverside Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Yard Foreman	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME George E. Akehurst Sr		15. MOTHER'S MAIDEN NAME Molly Malloy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 705-09-4999	
17. INFORMANT George E. Akehurst		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cordone arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Car collision</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 49 1987			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. A. Towhidian MD				22c. DATE SIGNED 9/2/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Towhidian	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/4/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md				23e. ADDRESS 3236 Mountain Rd. Pasadena Md, 21122			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR SEP 04 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits are to be attached to the death certificate and the burial-transit permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

BP

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SEP 04 1989

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FOR
STATE
REGISTRATION
DCT 207STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24810
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Betty L. Alton			2a. DATE OF DEATH MONTH DAY YEAR Sept 27, 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD			13b. COUNTY AA	13c. CITY OR TOWN Annapolis	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen McDonaldson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emmalee Shifflet		16. ADDRESS 48 Silopanna Road Annapolis, MD 21403	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-1330		17. INFORMANT Kenneth A. Alton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>end stage renal disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute peritonitis</u>					
19a. DATE OF OPERATION <u>9-23-87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>9-23-87</u> to <u>9-27-87</u> , that (b) (we) lost <u>saw the deceased alive on 9-23-87</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>G. Mitchell</u>		DEGREE		22c. DATE SIGNED <u>9/28/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G Mitchell MD</u>		22e. ADDRESS <u>205 Ridge Ave Annapolis MD 21401</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept 30, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis AA MD</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>Taylor Funeral Chapel-Annapolis MD</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 1 1987</u>	
		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP _____



066317 SEP 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2481 EDT

1. DECEASED NAME (TYPE OR PRINT) DORIS MAE AMADIO			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1987			2b. HOUR 745 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 08 06 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Oper			12b. KIND OF BUSINESS OR INDUSTRY Public Ser.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE California 13b. CITY OR TOWN Santa Rosa					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 121 Fleming Way 95407		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 545 03 9850		17. INFORMANT Santa Rosa, California 95407 Alice M. Gambriel 121 Fleming Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>87</u> , to <u>9/18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Marc Kaplan</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D.						22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (19) CREMATION			23b. DATE 9/21/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md		
24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md. 21061						25a. DATE REC'D. BY REGISTRAR SEP 21 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Darden</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHAM 16 50M 1/81
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR Andrews					REG. NO. 24818				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fannie Andrews					2. DATE OF DEATH MONTH DAY YEAR 9 10 87 2b HOUR MIN 12 10 AM				
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 6 08 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Arne Arundel County MD.			
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Merridean Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Control Inspector		12b. KIND OF BUSINESS OR INDUSTRY Nine Corp.	
13a. STATE MD		13b. COUNTY Arne Arundel		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 847 Mill Creek Rd. 21012	
14. FATHER'S NAME FIRST MIDDLE LAST LaSelle Dykes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Malone					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Mildred Dutrow		ADDRESS same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYELOGENOUS LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1973 , 19____, to 9/10/87 , 19____, that (I) (we) last saw the deceased alive on 8/27/87 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harry Markins				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. MARKINS				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 12, 87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD			
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO				25. DATE REC'D. BY REGISTRAR 25a. REGISTRAR'S SIGNATURE SEP 17 1987 Julia Davidson-Parker					

BP _____

RECEIVED

20% COTTON

SEVERAL PARK M. S. 1987

SEP 17 1987

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24817
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Albert Baker			2a. DATE OF DEATH MONTH DAY YEAR 9-29-87		2b. HOUR 9 ²⁵ M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 6, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD		
10. CITY OR TOWN OF DEATH Pasadena	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8252 Silver Run Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Guard
13a. STATE Maryland			13b. COUNTY AA	13c. CITY OR TOWN Pasadena	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Baker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Mae Tivens		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-10-3999		17. INFORMANT ADDRESS Jane Miller, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>terminal cancer of lung (large cell mixed)</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Long history smoking / chronic obstructive lung disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE September 24, 1984 September 29, 87 3708 Mountain Rd. Pasadena, Anne Arundel MD	
22a. I certify that (I) (this hospital) attended the deceased from above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. D. Sparkle M.D. Terry D. Sparkle		DEGREE M.D.		22c. DATE SIGNED 9-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
James S. Kirkley, Glen Burnie, MD		3708 Mountain Rd. Pasadena, Anne Arundel MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR OCT 02 1987		25b. REGISTRAR'S SIGNATURE Julia Dandridge-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

162-130 000700

065298 SEP

FOR
DATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 24820
REG. NO

1. DECEASED NAME (TYPE OR PRINT) NICHOLAI I. BARNATNY			2a. DATE OF DEATH MONTH DAY YEAR Sept. 3, 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co., MD.	
10. CITY OR TOWN OF DEATH Brooklyn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4105 Ritchie Highway (21225)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) News Editor		12b. KIND OF BUSINESS OR INDUSTRY Gov. Radio
13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Brooklyn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ivan Barnatny		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Smilnitskaya		13e. STREET ADDRESS / ZIP CODE 4105 Ritchie Hwy. (21225)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN	17. INFORMANT ADDRESS Alex Barnatny, 610 Bourbon St., 21078			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infectious colon CA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Seps</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N/A</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1987</u> to <u>August 1987</u> , that (I) (we) <u>did</u> saw the deceased alive on <u>August 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Carol B. Miller MD</u>		DEGREE MD		22c. DATE SIGNED 9/4/1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROLE B. MILLER MD		22e. ADDRESS Johns Hopkins Oncology Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/5/1987	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hwy., Baltimore		MD ADDRESS (21225)		25a. DATE REC'D. BY REGISTRAR SEP 09 1987	
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

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CHIEF EXAM

BOX COLLIDN FIBER

DOWN

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SEP 08 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (FIRST, MIDDLE, LAST) FREDERICK Raymond BATHON SR				2b. DATE OF DEATH (MONTH, DAY, YEAR) SEPTEMBER 3, 1987		2c. HOUR 123 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH, DAY, YEAR) August 25, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR (MONTHS, DAYS, HOURS, MIN.)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Sun Papers	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST, MIDDLE, LAST) Bathon				15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) Josephine C. Sanders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 217-14-5074		17. INFORMANT ADDRESS Pasadena, Md 21122 M. Elaine Bamberger 8606 Black Rock Harbor					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>retained secretions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>congestive heart failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1985</u> to <u>Sept 3, 1987</u> , that (I) (we) lost <u>above</u> the deceased <u>on</u> <u>Sept 3, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.				22e. ADDRESS 653 OLD MILL ROAD MILLERSVILLE, MARYLAND 21108					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/87		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR SEP 04 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

06 4 8 2 0 SEP - 9 81

ALVIN ARNOLD CO. 21

FACTORY, HUNTERS HILLS

HEATH HILLS

100-100000-100000

100-100000-100000

100-100000-100000

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100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR
1 - STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)
ALONZO RYLAND** BENNETT JR

RYLAND**

BENNETT

JR

2a. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 06, 1987

2b. HOUR
1302 M

3. SEX
male

4. RACE
black

5. DATE OF BIRTH
MONTH DAY YEAR
12 12 1907

6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS.

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md

7b. CITIZEN OF WHAT COUNTRY?
U S A

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD.

10. CEMETERY OR PLACE OF BURIAL
GLEN BURNIE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
NORTH ARUNDEL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN

Md

A.A.

Glen Burnie

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE
366 Gaylor Road 21061

14. FATHER'S NAME
FIRST MIDDLE LAST
Alonzo R. Bennett, Sr

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Scott

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
214-40-5856

17. INFORMANT ADDRESS
Alonzo Bennett III 366 Gaylor Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Severe Hemiparesis

1 hr

DUE TO, OR AS A CONSEQUENCE OF

(c)

CH lung

1 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I (this hospital) attended the deceased from 9/6 1987, to 9/6 1987 that (I/we) last saw the deceased alive on 9/6 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DAVID A. SCHWARTZ, D.O.

22e. ADDRESS

7845 OAKWOOD ROAD GLEN BURNIE, MD 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
9/10/87

23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery

23d. LOCATION CITY OR TOWN

Anne Arundel Co

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

Wm. C. March F/H West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 09 1987 *Julian Anderson-Randall*

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ALWAYS

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BEHOLD

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SEPTEMBER 06, 1987 1305 P

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AND WINDMILL COUNTRY

NORTH ARMDALE HOSPITAL

GLEN DUNNIE

20% COTTON REFINED

GLEN DUNNIE, MD 21061
1845 OAKWOOD ROAD

DAVID A. SCHWARTZ, D.O.

SEP 09 1987

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065276 SEP 14 1987

FOR
STATE
REGISTERARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 4 8 2 3

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST CHARTAE AIMEE BENTON			MONTH DAY YEAR 09 06 87			1252 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
FEMALE	BLACK	MONTH DAY YEAR 12 12 85	20 MONTHS YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
WASH., D.C.	USA		ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
FT. MEADE, MD.	KIMBROUGH ARMY COMMUNITY HOSPITAL		N/A			N/A		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD	AA	SEVERN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8332 DEER RUN CT., SEVERN, MD. 21144				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
SILAS VEDAN BENTON			DARLENE KIM HILL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
N/A			N/A			MOTHER 8332 DEER RUN CT., SEVERN, MD. 21144		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGENITAL ABNORMALITIES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
<u>HYDROCEPAHLUS</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE				22c. DATE SIGNED
<i>William Thompson</i>				M.D.				9/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
WILLIAM THOMPSON M.D.				KIMBROUGH ARMY COMMUNITY HOSPITAL, FGM, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		9/10/87		CEDAR HILL CEMETERY		ANNE ARUNDEL CO., MD		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR				
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE				SEP 09 1987				

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SEP 09 2001

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24829
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LIBBYE BERLIN			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 30, 1987		2b. HOUR 2:15 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 11, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY STATE OF MD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY BALTO.		13c. CITY OR TOWN RANDALLSTOWN		
14. FATHER'S NAME FIRST MIDDLE LAST MEYER DAVID				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LI'ELIAN KLAFF				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-18-4428A		17. INFORMANT LEILA BERLIN ADDRESS APT. 103 3918 NOYES CIR. RANDALLSTOWN, MD 21133				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimer's & Parkinson's Disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>87</u> , to <u>9/29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Lawrence Solomon</u> M.D.				DEGREE M.D.		22c. DATE SIGNED 9/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE SOLOMON, M.D.				22e. ADDRESS 4000 OLD COURT RD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT - 6 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

067750 OCT-1-81

MAINT. INSTRUCTIONS

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FOR
14-87
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH24023
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE Beth		LAST Billings		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH 9		DAY 5		YEAR 1987		2b. HOUR 1210							
3. SEX F		4. RACE CAU		5. DATE OF BIRTH MONTH 12		DAY 23		YEAR 86		6. AGE (IN YEARS) LAST BIRTHDAY 8		IF UNDER 1 YR. MONTHS 8		IF UNDER 24 HRS. DAYS 13		2c. DATE PRONOUNCED DEAD MONTH 9		DAY 5		YEAR 87		2d. HOUR 1210	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.		10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES		NO		13e. STREET ADDRESS 7654 Solley Rd.		14. FATHER'S NAME FIRST David		MIDDLE A.		LAST Billings		15. MOTHER'S MAIDEN NAME FIRST Sandra		MIDDLE A.		LAST Sanderlin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT David		ADDRESS Pasadena Md. 21122		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Tuberous Sclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES		NO		21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE William P. Jones, M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 9/5/87		EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Ct. 21035		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/8/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Demetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.					
24. FUNERAL DIRECTOR NAME George Gonce		ADDRESS 4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR SEP 09 1987		25b. REGISTRAR'S SIGNATURE John D. Anderson																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1000, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24820

1. DECEASED NAME (TYPE OR PRINT) Leah K Boock		2a. DATE OF DEATH MONTH DAY YEAR 9 18 77		2b. HOUR 12:03 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Mar. 15 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Slocum, Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Arundel General Hospital		12a. USUAL OCCUPATION (IF OTHER THAN WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3721 6th Ave. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Whitebread			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Sims		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 207-56-6923		17. INFORMANT ADDRESS James D. Boock Same as Above 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from before Sept 10 , 19 77 , to Sept 17 , 19 77 , that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE CHIEF CLERK FOR ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold Teitelbaum MD			22e. ADDRESS 139 old Locomotion Inc. Annapolis MD 21401		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-22-87		23c. NAME OF CEMETERY OR CREMATORY Slocum Methodist Church Slocum Lazerne Penn.	
24. FUNERAL DIRECTOR NAME ADDRESS Beall-Evans Funeral Home Annapolis, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 24 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24821

1. DECEASED AKA: Casmier (NMN) Borek Borek			2a. DATE OF DEATH September 30, 1987			2b. HOUR 3:55P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 14, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2730 Bayside Beach Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Knipp Co.	
13a. STATE Maryland		13b. COUNTY A.A. CO.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 110 Benmere Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Borek				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		16c. 213.30.6792		17. INFORMANT (Daughter) ADDRESS Mrs. Agnes I. Whisenant 8216 Bayside Dr Pasadena, Md 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>progressive non-small cell lung cancer</u> 10 mos. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>January 12</u> , 19 <u>87</u> to <u>September 30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>September 22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Aron W. Berkman</u>				DEGREE M.D.				22c. DATE SIGNED 10/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aron W. Berkman, M.D.				22e. ADDRESS So. Baltimore General Hospital Baltimore, Maryland 21230					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24020

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Golfe Bounellis			Sept. 7, 1987			4:55 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
Female	White	Aug. 12, 1924	63			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Maryland	USA		Anne Arundel MD			Retired		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Crofton	Crofton Convalescent Center		Retired			Board of Ed.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD			AA			Annapolis		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
William C. Katsereles			Christina Lewnes			No		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
216-18-5664			George P. Bounellis			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>COPD</u>								3 yrs
(c) <u>urosepsis</u>								4 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>abdominal illness</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>July 85</u> to <u>Sept 7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<u>Paul Berez</u>								<u>9/9/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Paul Berez MD						1655 Crofton Blvd Crofton MD 21114		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Sept 9, 1987		St. Demetrius		Annapolis AA MD		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Taylor Funeral Chapel-Annapolis, MD				SEP 10 1987		<u>Julia Davidson-Rudolph</u>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24829

1. DECEASED NAME (TYPE OR PRINT) Philip Owen Bowman				2a. DATE OF DEATH MONTH DAY YEAR Sept. 29 1987		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7 1912		6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Manager		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE MD		13b. COUNTY AA.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Bowman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Enlow		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b. SOCIAL SECURITY NO. 217-105448	
17. INFORMANT Nellie E. Bowman		ADDRESS Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lippen's Calculus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/P Pulmonary Emphysema</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (the hospital) attended the deceased from above, (I) (we) (did not) view the body after death.		21h. DATE SIGNED	
21i. SIGNATURE Margaret M. Mullens, MD		21j. ADDRESS 1620 Cape St. Claire Rd, Annapolis MD		21k. DATE SIGNED		21l. PHYSICIAN'S NAME (TYPE OR PRINT)	
21m. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		21n. DATE Oct. 1, 1987		21o. NAME OF CEMETERY OR CREMATORY Hillcrest		21p. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
21q. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		21r. ADDRESS		21s. DATE REC'D. BY REGISTRAR OCT 1 1987		21t. REGISTRAR'S SIGNATURE Julia Davidson-Roads	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24830

1. DECEASED NAME (TYPE OR PRINT) CHRISTINA NMN BRACEY			2a. DATE OF DEATH MONTH DAY YEAR 09 07 87		2b. HOUR 0510AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 07 83		6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH FT. MEADE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY COMMUNITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY A. ARUNDEL	13c. CITY OR TOWN FT. MEADE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK BRACEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE HUNT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Frederick Bracey Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) BRAIN TUMOR

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Bruce Bridewell</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9/7/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE BRIDEWELL, M.D.		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/14/87	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home, Annapolis, Md.		25a. DATE REC'D BY REGISTRAR SEP 15 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified at once.

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Handwritten signature

SEP 18 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 24831
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Daniel Breighner		2a. DATE OF DEATH MONTH DAY YEAR September 3 1987		2b. HOUR AM PM 10 AM	
3. SEX Male	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR October 15 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH PASADENA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 Ritchie Hwy		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAPER HANGER		12b. KIND OF BUSINESS OR INDUSTRY Self
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND	13c. COUNTY Anne Arundel	13d. CITY OR TOWN PASADENA	13e. STREET ADDRESS / ZIP CODE 6 Ritchie Hwy 21122		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET Schattle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 220 10 0086		17. INFORMANT ADDRESS ROSALIE PARFITT (Daughter) 32 Carroll Rd RT 14 PASADENA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-10 yrs 10 years 18 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's Disease old stroke Sever Arthritis of Spine Irritation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 6 Aug 19 76 to 3 Sep 19 87 , that (I) (we) lost saw the deceased alive on 6 Aug 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. C. Callis MD		DEGREE		22c. DATE SIGNED Sep 3 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. C. CALLIS MD		22e. ADDRESS 7 Rags Ave Severna Park Md. 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8 Sept. 87		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Alleganey MD					
24. FUNERAL DIRECTOR NAME James S. Kirkley,		421 Crain Hwy. S.E. Glen Burnie, MD 21061		25a. DATE REC'D. BY REGISTRAR SEP 04 1987	
25b. REGISTRAR'S SIGNATURE John Davidson					

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DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the certificate and this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) DOROTHY M BREMER		2a. DATE OF DEATH MONTH SEPTEMBER DAY 11 YEAR 1987		2b. HOUR 1047 AM	
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH 10 DAY 20 YEAR 1920	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Severna Park	
14. FATHER'S NAME FIRST John MIDDLE Wiese LAST Wiese		15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Schmidt LAST Schmidt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220012394		17. INFORMANT ADDRESS Richard K. Bremer (Same as Above 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPOST? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) lost saw the deceased alive on 9/5/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jose M. Presbitero M.D.		DEGREE M.D.		22c. DATE SIGNED 9/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, #107 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-14-1987		23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. MD					
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...	
24. FUNERAL DIRECTOR ADDRESS SEVERNA PARK, MD. 21146					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

067721 OCT 17 1987

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) ALGERIE RAE BRIGERMAN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1987			2b. HOUR 410 MM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Procter & Gamble	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Glen Burnie, Md. 1425 Gordon Dr. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Hoyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary R. Kohl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT (Husband) Milton O. Brigerman		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>162 aspirin - pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>162 aspirin - pneumonia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral hemorrhage & seizure disorder</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/1/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YONG H. OH, M.D.				22e. ADDRESS 1412 CRAIN HIGHWAY NORTH GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24839

1. DECEASED NAME (TYPE OR PRINT) MARGARET E. BROWN			2a. DATE OF DEATH MONTH DAY YEAR September 12 1987			2b. HOUR M 344P				
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR FEB 15 1935		6. AGE (IN YEARS LAST BIRTHDAY) 54		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1909 B. Copeland Street 21401	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES E. BUTLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES NAYLOR			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 215-28-7172			17. INFORMANT Annapolis, Md. 21401 WILLIAM BROWN 1909 B. Copeland Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic DUE TO, OR AS A CONSEQUENCE OF ASBESTOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from July 20 , 19 87 , to September 12 , 19 87 , that (I) we lost saw the deceased alive on 9/15 , 19 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.										
22b. SIGNATURE Donald C. Roane, M.D.			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Roane, M.D.			22e. ADDRESS 1616 Forest Drive Annapolis 21402							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-22-1987		23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			ADDRESS Annapolis, Md. 21401			25a. DATE REC'D. BY REGISTRAR SEP 22 1987		25b. REGISTRAR'S SIGNATURE Julia Swinton		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

65283 SEP 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remain in the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other unusual event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2 4 8 3 2

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) GLENN E. BRYAN		2b. DATE OF DEATH MONTH DAY YEAR 09. 06. 87		2c. HOUR 1535 M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR SEPT 3, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Gambrills	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2395 Ginger Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Finance Manager		12b. KIND OF BUSINESS OR INDUSTRY Consulting	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Chester Bryan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Hawkins		13e. STREET ADDRESS / ZIP CODE 2395 Ginger Drive 21054			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-56-0372		17. INFORMANT Nancy B. Bryan ADDRESS 2395 Ginger Drive Gambrills, Maryland 21054			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Leukemic CNS INFILTRATE DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 19 87 , to 9.6 19 87 , that (1) (we) lost above, (1) (we) did not view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Michael J. Latenta		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 09.06.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. LATENTA MD		22e. ADDRESS 7036 GARDENS AVE ANNAPOLIS MD 21404					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE SEPT 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Lakemont Memorial Gdn. Davidsonville, A. A., MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Deane F. H. [Signature]		ADDRESS 16000 Annapolis Road 20715		25a. DATE REC'D. BY REGISTRAR SEP 09 1987			

BP

067455 OCT-28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24830
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD RUSSELL BURL			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 28, 1987		2b. HOUR 8:00 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1913		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 508 Oakwood Road, 21061		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman Ret.			12b. KIND OF BUSINESS OR INDUSTRY Aluminum			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Glen Burnie 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 508 Oakwood Rd., 21061						
14. FATHER'S NAME FIRST MIDDLE LAST Edward NMN Burl			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-05-5076		17. INFORMANT ADDRESS Mrs. Anna E. Higgins Same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) AHD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden death 25 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Hypertension, Atrial Fibrillation

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 6, 1961, to Sept 28, 1987, that (I) (we) last saw the deceased alive on 9/25/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph Taler		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Taler, M.D.		22e. ADDRESS 95 Aquahart Rd., Glen Burnie, Md. 21061					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/1/87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS McCurly Funeral Homes Balto., Md. 21225				25a. DATE REC'D. BY REGISTRAR OCT 01 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

067166 SEP 30 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24837

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RENA Louise BYRNE		2a. DATE OF DEATH MONTH DAY YEAR September 25, 1987		2b. HOUR 1:35 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BROOKLY PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER, HAMMONDS A.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB Koehl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 529 MUNROE CIRCLE 21061	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NONE		16b. SOCIAL SECURITY NO. 212-22-8133		17. INFORMANT (Friend) ADDRESS Elwood L. Fletcher 224 N. Hammonds Ferry Rd. Linthicum, Maryland 21090	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MULTIINFARCT DEMENTIA.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 8/22, 1987 to 9/25, 1987 , that (1) (we) lost saw the deceased alive on 9/24, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.							
22b. SIGNATURE K. S. DHARMA SENA				DEGREE		22c. DATE SIGNED 9/25/1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. S. DHARMA SENA				22e. ADDRESS 5507-E RITCHIE HIGHWAY BALT.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 28, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the hospital administrator should be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by me or another physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please promptly return page 3 to the funeral director. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4838

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LEO JOHN CAFFEY			2. DATE OF DEATH MONTH DAY YEAR SEP 20 87			2b. HOUR 0130 M	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 9 24 26	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH PT MEADE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL WORKER		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing		
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN JESSUP	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE E 29 HOLIDAY MOBILE ESTATES 20794		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES CAFFEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH LONG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 199-12-0666		17. INFORMANT Jessup, Maryland 20794 Gertrude I. Caffrey E29 Holiday Mobil			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>							Home Estates
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; previous history of Myocardial Infarct.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>9/20 1987</u> to <u>9/20 1987</u> , that (1) (we) last saw the deceased alive on <u>9/20 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (If kept (to) (ed) not view the body after death.							
22b. SIGNATURE <u>Ben Potkin MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Potkin		22e. ADDRESS Kimbrough Army Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/23/87		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vets.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md	
24. FUNERAL DIRECTOR NAME Raymond C. Fink				ADDRESS Glen Burnie, Md 21061		25a. DATE REC'D. BY REGISTRAR SEP 21 1987	
				25b. REGISTRAR'S SIGNATURE Julia Darden-Rose			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24839 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE F LAST CHASE			2a. DATE OF DEATH MONTH SEPTEMBER DAY 14 YEAR 1987		2b. HOUR 700 PM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 9 DAY 27 YEAR 1931		6. AGE (IN YEARS LAST BIRTHDAY) 65 IF UNDER 1 YEAR: MONTHS _____ DAYS _____ IF UNDER 24 HRS: HOURS _____ MIN. _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST THOMAS MIDDLE BELT LAST		15. MOTHER'S MAIDEN NAME FIRST HELEN MIDDLE HARRIED LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Annapolis, Md. 21401 BARBARA K. CLARK 1806 I. Copeland Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio. pulmonary arrest (b) Cerebral hypoxia (c) XSCUD DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART I (a) Sept 15 Suspect @ Rept. 15					
19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 9/14 1987 to 9/14 1987, that (I) (we) last saw the deceased alive on 9/14 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE Elmo M. GAYOSO, M.D.		DEGREE M.D.		22c. DATE SIGNED 9/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELMO M. GAYOSO, M.D.		22e. ADDRESS 5411 OLD FREDERICK ROAD BALTIMORE MARYLAND 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-19-1987	23c. NAME OF CEMETERY OR CREMATORY BREWER HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, A.A. Maryland
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			25a. DATE REC'D. BY REGISTRAR SEP 22 1987		
25b. REGISTRAR'S SIGNATURE Julia Dandor					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3, and place them in the folder provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

066561 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24840 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE B. CLARKE			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 21, 1987		2b. HOUR 535 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC. 07, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21061 104 H. GOVERNORS CT.	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE J. SCHRUER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY K. BURGAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-9998		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 DAYS 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 18, 1987, to SEPT. 21, 1987, that (I) (last) saw the deceased alive on SEPT. 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE M.D. ATTENDING PHYSICIAN		22c. DATE SIGNED 9-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE VIDAVER, M.D.		22e. ADDRESS 420 SOUTH CRAIN HIGHWAY, #3 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 09-23-1987	23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. CO. MD.
24. FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES			25a. DATE REC'D. BY REGISTRAR SEP 22 1987		
			25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24841

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carroll Murray Cole, Sr.			2. DATE OF DEATH MONTH DAY YEAR September 23, 1987		3. HOUR 1:00PM
4. SEX Male	5. RACE White	6. DATE OF BIRTH MONTH DAY YEAR March 7, 1917	7. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	8. UNDER 1 YEAR MONTHS DAYS 70	9. UNDER 22 HRS. HOURS MIN. 70
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	11. CITIZEN OF WHAT COUNTRY? USA	12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	13. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD		
14. CITY OR TOWN OF DEATH Millersville	15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1370 Coleus Drive		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming (Ret)		17. KIND OF BUSINESS OR INDUSTRY A A Co.
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a. STATE Maryland	18b. COUNTY A A Co.	18c. CITY OR TOWN Millersville	18d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	18e. STREET ADDRESS / ZIP CODE 1370 Coleus Drive 21108	
19. FATHER'S NAME FIRST MIDDLE LAST Wilbur Cole	20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viva Boyer		21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No NA		
22. SOCIAL SECURITY NO. 220.07.9877	23. INFORMANT (Wife) Thelma A. Cole		24. ADDRESS Same as #13		
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PANCREATIC CANCER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
26. DATE OF OPERATION	27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART 1, OR PART 2)			
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)	35. LOCATION STREET CITY OR TOWN COUNTY STATE December 86 September 87			
36. I certify that (1) the hospital attended the deceased from September 87 to September 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					
37. SIGNATURE Ross C. Donkower		38. DEGREE MD	39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	40. DATE SIGNED 9.24.87	
41. PHYSICIAN'S NAME (TYPE OR PRINT) Ross C. Donkower		42. ADDRESS Johns Hopkins Oncology Center.			
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	44. DATE Sept 27, 1987	45. NAME OF CEMETERY OR CREMATORY Baldwin United Meth. Church Cemetery	46. LOCATION CITY OR TOWN COUNTY STATE Millersville A A Co. Maryland	47. DATE REC'D. BY REGISTRAR	
48. FUNERAL DIRECTOR NAME Singleton Funeral Home		49. ADDRESS Glen Burnie, Maryland		50. REGISTRAR'S SIGNATURE Julia Davidson-Randall	51. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked as injury, or other traumatic event, the medical examiner should be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24342

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reba Evelyn Collier			2a. DATE OF DEATH MONTH DAY YEAR September 6, 1987		2b. HOUR 2:10a M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1922		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) News American Delivery Person		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Q.A.		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John William Tull		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Daniels		16. STREET ADDRESS / ZIP CODE 12 Thompson Creek Rd. 21666			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-28-2256		17. INFORMANT ADDRESS Elwood Collier, same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/5 87 to 9/6 87		21g. I certify that (I) (this hospital) attended the deceased from 9/6 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22a. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. K. Men				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-09-87		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. MD	
24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Home, Chester, MD 21619				25. DATE REC'D. BY REGISTRAR SEP 14 1987			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified in writing.

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John W. ...

June 22, 1952



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 24843

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Luella H. Collings			2a. DATE OF DEATH MONTH 9 DAY 14 YEAR 87			2b. HOUR 9:30 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 2 DAY 08 YEAR 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Florida CITY OR TOWN Port Orange				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 484 Autumn Trail 32019			
14. FATHER'S NAME FIRST CHARLES MIDDLE HILL LAST HILL				15. MOTHER'S MAIDEN NAME FIRST GRACE MIDDLE FREY LAST FREY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII		17. INFORMANT NAME Michael Z. Collings ADDRESS 25632 Pennie Dearborn Heights, Mich. 48126					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Profound Unresponsive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Anemia 20% Blood loss of Surgery DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac fibrillation									INTERVAL BETWEEN ONSET AND DEATH 3 hours - 3 hours 2 hr -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Surgery for Resection of Aortic Aneurysm and Aortic Femoral Bypass									
19a. DATE OF OPERATION 9-14-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemia in legs -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 15 , 19 87 , to Sept 14 , 19 87 , that (I) (we) last saw the deceased alive on 14 Sept , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gary M. Richardson, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. RICHARDSON, M.D.				22e. ADDRESS 104 Forbes Street, Annapolis, Md. 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-16-87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Virginia			
24. FUNERAL DIRECTOR NAME Beatl-Evans Funeral Home ADDRESS Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR SEP 16 1987		25b. REGISTRAR'S SIGNATURE A. E. P. P. P.			

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Alaska

Charles Hill Bruce Ford

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4344

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Harriet</i> MIDDLE <i>V.</i> LAST <i>Conaway</i>		2a. DATE OF DEATH MONTH <i>9</i> DAY <i>27</i> YEAR <i>87</i>		2b. HOUR <i>8:15 A.M.</i>	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>3</i> DAY <i>1</i> YEAR <i>08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Ann Arundel</i> MD.		10. CITY OR TOWN OF DEATH <i>Odenton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>514 Camelot Court</i>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Ann Arundel</i> 13c. CITY OR TOWN <i>Odenton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>514 Camelot Court 21113</i>	
14. FATHER'S NAME FIRST <i>George</i> MIDDLE <i>Newton</i> LAST <i>Royston</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i> MIDDLE <i>Utterback</i> LAST <i>Utterback</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT ADDRESS <i>Virginia McCartney</i> <i>514 Camelot Ct Odenton MD 21113</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic malignant Schwannoma</i> 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>hypertension, congestive heart failure</i>					
19a. DATE OF OPERATION <i>8/28/86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>malignant Schwannoma</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>8/29</i> 19 <i>86</i> to <i>9/27</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/27</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Marc E. Boisvert</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Marc E. Boisvert</i>		22e. ADDRESS <i>3450 Ft. Meade Rd., Laurel, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/30/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Good Shepard Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ellicott City Howard MD</i>		23e. DATE REC'D. BY REGISTRAR <i>OCT 02 1987</i>			
24. FUNERAL DIRECTOR <i>Fleck Funeral Home Inc.</i> ADDRESS <i>7601 Sandy Spring Rd Laurel MD 20707</i>		25. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24845

1. DECEASED NAME (TYPE OR PRINT) Mable M. Connelly			2a. DATE OF DEATH MONTH DAY YEAR 9-16-1987		2b. HOUR 1:10 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 2 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Ann Arundel MD	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Brk Factory
13a. STATE Maryland	13b. COUNTY C. C. Co	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Eugene - Winkel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Boyd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-075883		17. INFORMANT John Busch 7970 Nolcrest Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) End stage heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Aortic & atrial fibrillation					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. years years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. COPD					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August , 19 87 , to Sept. 16 , 19 87 , that (I) (we) last saw the deceased alive on Sept 15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.					
22b. SIGNATURE B. Shalig, MD		DEGREE MD		22c. DATE SIGNED 9/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHABAZZ MD		22e. ADDRESS 7231 Ritchie Highway D-1 Glen Burnie 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-19-1987		23c. NAME OF CEMETERY OR CREMATORY London PK CEMETERY Balt. more	
24. FUNERAL DIRECTOR NAME John J. Bowman & Son Inc.		ADDRESS 9017 Hollins		25a. DATE REC'D. BY REGISTRAR SEP 22 1987	
				25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall	

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then all pages should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME FIRST MIDDLE LAST L. LORRAINE Cook					2. DATE OF DEATH MONTH DAY YEAR HOUR 9 3 87 9 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Sec.		12b. KIND OF BUSINESS OR INDUSTRY A.A. Bd. of Ed.	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4795 Mountain Rd. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST James Jubb			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha E. Whittemore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-26-3281		17. INFORMANT ADDRESS Jefferson M. Cook, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ocular Melanoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>87</u> , to <u>9/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased <u>above</u> <u>9/1</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)									
22b. SIGNATURE <u>E W Cole</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE				22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 Sept. 87		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pasadena, A.A., MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley		421 Crain Hwy. S.E. Glen Burnie, MD 21061		25a. DATE RECD. BY REGISTRAR SEP 04 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO. 2 4 8 4 7

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Morothy E. Creswell</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>9-27-87</i>		2b. HOUR A.M. <i>7:00</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 23, 1910</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>77</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1019 Fitzallen Road</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County MD</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Glen Burnie</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>N/A</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>N/A</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired - R.N.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-12-0260</i>		17. INFORMANT ADDRESS <i>Roland L. Creswell, Sr., Same as 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio Sclerosis Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Renal Cerebral - Anemia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-27-87</i> , 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>9-27-87</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Alfredo Montoya</i>		DEGREE		22c. DATE SIGNED <i>9-27-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfredo Montoya</i>		22e. ADDRESS <i>7845 Oakwood Rd Glen Burnie Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 30, 87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Baltimore</i>		COUNTY <i>AA</i>		STATE <i>MD</i>	
24. FUNERAL DIRECTOR NAME <i>James S. Kirkley, Glen Burnie, MD</i>		25a. DATE REC'D. BY REGISTRAR (I) REGISTRAR'S SIGNATURE <i>SEP 28 1987</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 28 1952

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 17th inst. in relation to the above.

Enclosed for you are the documents requested.

I am, Sir, very respectfully,
Yours truly,

Wm. A. [Signature]

Very truly yours,

Wm. A. [Signature]

cc - [illegible]

SEP 28 1952

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SEP 14 87
STATE
REGISTRAR

Film G632 item 16a

10/8/87 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 2 4 3 4 8

1. DECEASED NAME (TYPE OR PRINT) DAVIS CRICKENBERGER			2a. DATE OF DEATH MONTH DAY YEAR 9-5-87		2b. HOUR 1950	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3-4-20		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Developer		12b. KIND OF BUSINESS OR INDUSTRY Land	
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN GODDARD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 224 RIVERSIDE RD. 21037		
14. FATHER'S NAME FIRST MIDDLE LAST Leon S. Crickenger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorena Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No yes <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) -		16b. SOCIAL SECURITY NO. 577-14-0544		17. INFORMANT ADDRESS Jean E. Crickenger - #13 Same as		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Cancer of Colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years -						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from March 1987 to March 1987 , that (I) (we) saw the deceased alive on March 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.						
22b. SIGNATURE Peter F. Verkow				22c. DATE SIGNED 9/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOW MD				22e. ADDRESS 1833 FOREST DRIVE ANNAPOLIS MD 21401		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 9, 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA MD		25a. DATE REC'D. BY REGISTRAR SEP 10 1987				
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis MD		25b. REGISTRAR'S SIGNATURE Alia Tinker-Rudell				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and send with page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24849

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Virginia Marie D'Andrea				September 8, 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	White	Nov. 21, 1914		72 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.	USA			Anne Arundel County		MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Pasadena	1776 Nanticoke Road		Homemaker				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Md.	Anne Arundel	Pasadena		1776 Nanticoke Road 21122			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
-		Ludwig -					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		216-10-7000A		Mr. Robert A. D'Andrea Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct.</u> DUE TO, OR AS A CONSEQUENCE OF <u>H.A.S.C.M.D.</u> (b) <u>old. Rt. sided hemiplegia due to CVA.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C.O.P.D.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes: years: 12 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> , 19 <u>72</u> , to <u>Sept 8</u> , 19 <u>87</u> , that (I) <u>see</u> last saw the deceased alive on <u>Jan 9</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> did not view the body after death.							
22b. SIGNATURE <u>Atallah Golpira</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-8-1987</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ATALLAH GOLPIRA, M.D.</u>		22e. ADDRESS <u>3029 Dundalk Ave. Balto, Md. 21222</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u>		23b. DATE <u>Sept. 11, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE		
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck, Inc. Baltimore, Maryland</u>		25a. DATE RECEIVED BY REGISTRAR <u>SEP 9 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Dindor-Randall</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24858

1. DECEASED NAME (TYPE OR PRINT) ELLANORA CATHERINE DAVIS			2a. DATE OF DEATH MONTH DAY YEAR Sept. 19, 1987		2b. HOUR P 9:00 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4/10/1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH N. Linthicum		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 722 Wedeman Avenue, 21090		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY Hutzler's
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN N. Linthicum	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 722 Wedeman Ave., 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Vickers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Bisser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-34-4319		17. INFORMANT 3508 Shenandoah Ave., Mrs. Vera Kinstler Balto. Md. 21227	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer right lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 6</u> 19 <u>87</u> to <u>Sept 19</u> 19 <u>87</u> that (I) (we) lost <u>her</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <u>Dr. Charles Wu, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>Sept 21 87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles Wu, M.D.		22e. ADDRESS 7845 Oakwood Rd., Glen Burnie, Md.	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/22/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Balto., A. A. Co., Md.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR SEP 22 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove signature papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24851

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES CARLTON DEGRUCHY			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 17, 1987		2b. HOUR 1026 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Balto. G. & E.	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 712 Elm Ave.		13f. CITY OR TOWN Baltimore		13g. STATE Maryland		13h. ZIP CODE 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Carlton DeGruchy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona L. Leonard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	
17. INFORMANT (Wife) Mrs. Reita M. DeGruchy		18. ADDRESS Same as #13		19. PHONE NO. #13		20. CITY OR TOWN Baltimore	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure - DUE TO, OR AS A CONSEQUENCE OF (c) CHF -		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		23. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ASPD -		24. MEDICAL CERTIFICATION	
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		25c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		25d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		26d. LOCATION CITY OR TOWN COUNTY STATE 9/13/87 9/17/87	
27a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION CITY OR TOWN COUNTY STATE 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21041		27d. I certify that (I) (the hospital) attended the deceased from 9/13/87 to 9/17/87 , that (I) (we) last saw the deceased alive on 9/17/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.	
28a. SIGNATURE George B. Ramirez, M.D.		28b. DEGREE M.D.		28c. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21041		28d. DATE SIGNED 9/18/87	
29a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		29b. DATE Sept. 21, 1987		29c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		29d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland	
30. FUNERAL DIRECTOR NAME G. H. Hubert		30b. ADDRESS 1 Second Ave. S. W. Singleton Funeral Home Glen Burnie, Md.		30c. DATE REC'D. BY REGISTRAR SEP 22 1987		30d. REGISTRAR'S SIGNATURE J. J. [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with you for 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WANE ARMY CORPS

NORTH ARMY HOSPITAL

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DAVIDSON ROAD

WANE ARMY CORPS
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

065352

SEP 14 1987

FOR
1 - STATE
REGISTRAR

87 REG. NO. 24852

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lucy Evans DORTCH</i>		20. DATE OF DEATH MONTH DAY YEAR <i>9 7 87</i>		26. HOUR <i>3:25 A</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 14 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maine</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Annapolis Convalescent Cntr.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>
13a. STATE <i>MD</i>	13b. COUNTY <i>AA</i>	13c. CITY OR TOWN <i>Annapolis</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>2446 Prince George St. 21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Evans</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna P. Maloney</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>659-14-7108</i>		17. INFORMANT <i>Margaret E. Dortch</i>		ADDRESS <i>Same as #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General deterioration (mal- nutrition; decubiti; renal failure) as a result of</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>12 months</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>12 months</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Alzheimer's dementia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:28 1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>1833 Forest Dr. Annapolis, MD 21401</i>	
22. I certify that (I) (the hospital) attended the deceased from <i>8/28</i> 19 <i>87</i> to <i>Present</i> 19 <i>87</i> , that (I) <i>well</i> saw the deceased alive on <i>8/28</i> 19 <i>87</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>well</i> (did) <i>not</i> view the body after death.					
22b. SIGNATURE <i>Peter F. VerKouwen</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>9-7-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PETER F. VERKOUWEN MD</i>		22e. ADDRESS <i>1833 Forest Dr. Annapolis, MD 21401</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>Sep 8 1987</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland P.G. MD</i>	
24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel-Annapolis MD</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rodgers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-removable tags. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still in progress.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been obtained and a list of the conclusions that have been drawn.

4. The fourth part of the report is a list of the references that have been used in the project.

5. The fifth part of the report is a list of the appendices that have been included in the project.

6. The sixth part of the report is a list of the figures that have been included in the project.

7. The seventh part of the report is a list of the tables that have been included in the project.

8. The eighth part of the report is a list of the other documents that have been included in the project.

068251 OCT 13 1987

FOR Item 5 Film G632 10-9-87
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24853

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR		
John Raymond Dougherty Jr.						9/ 30/19 87			M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			24 HOUR		
male	white	Feb 9, 1936	49 YRS.			9/ 30/19 87			3:03 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Wash DC			USA						Anne Arundel County, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General Hospital			Boat Captain			Waterman		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MD			AA			Deale			611 Clarke Ave/20751		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John Raymond Dougherty Sr						Mary Owens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				n/a		579 46 0122 Beverly I. Parks (same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Coronary Artery Thrombosis											
DUE TO, OR AS A CONSEQUENCE OF											
Arteriosclerotic Cardiovascular Disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
<i>Dennis F. Smyth</i>				Assistant				10/1/87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Dennis F. Smyth, M.D.				111 Penn St., Baltimore, Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation				10-4-87		Cedar Hill				Suitland PG MD	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Rausch FH Owings, MD 20736						OCT 05 1987			<i>Davidson</i>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL OFFICER, DIVISION OF VITAL RECORDS, WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BASIS FOR PREPARING PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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067421 OCT-21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24854

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick George Ecken, Jr			2a. DATE OF DEATH MONTH DAY YEAR Sept 29, 1987		2b. HOUR MIN. 5:25 A.M.						
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. UNDER 1 YEAR MONTHS DAYS YRS		8. UNDER 24 HRS. HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3056 Mimon Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Jewelry Store			
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3056 Mimon Road 21403			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick G. Ecken				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida E. Smith				16. ADDRESS Same as #13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-1954 217-240022		17. INFORMANT Jean E. Ecken				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma prostate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma prostate DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET 1277 GREEN HOLLY DR		CITY OR TOWN ANNAPOLIS, MD		COUNTY AA		STATE MD	
22a. I certify that (I) (this hospital) attended the deceased from Dec 23, 1986 , to Sept 28, 1987 , that (I) (we) (us) saw the deceased alive on 9-25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Brinkman Dettmer MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CORNERIA M. DETTMER						22e. ADDRESS 1277 GREEN HOLLY DR ANNAPOLIS, MD 21403					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN Annapolis		COUNTY AA		STATE MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel, Annapolis, MD						25a. DATE REC'D. BY REGISTRAR OCT 1 1987		25b. REGISTRAR'S SIGNATURE Julia Denson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

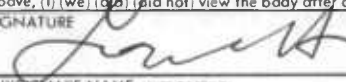
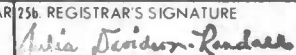
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified to the

066921 SEP 28 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24855

DECEASED NAME (TYPE OR PRINT) DORIS A ERBE		20. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1987		26. HOUR 852 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Food Service
13a. STATE Md		13b. COUNTY A.A.	13c. CITY OR TOWN Severn	13d. STREET ADDRESS 21144 7876 Dogwood Blossom Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Asa Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-30-3403		17. INFORMANT ADDRESS Russell E. Erbe Sr. #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 87 , to 9-20 , 19 87 , that (I) (we) last saw the deceased alive on 9-19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.		22e. ADDRESS 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-24-87	23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Md.	
24. FUNERAL DIRECTOR NAME ADDRESS T.A. Hardesty Annapolis Md. 21401		25a. DATE REC'D. BY REGISTRAR SEP 25 1987		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 when only injury, or other traumatic event, the medical examiner must be notified at once.

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065387 SEP 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24859 EDT

1. DECEASED NAME (TYPE OR PRINT) JOSEPH Patrick FITZGIBBONS, Jr.			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 05, 1987		2b. HOUR 4 15 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cheif of Title Pro. Md. MVA		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 223 C Woodhill Drive 21061
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Patrick Fitzgibbons Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes C. Cole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216.20.1516		17. INFORMANT (Wife) Charlotte A. Fitzgibbons Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral spinal Degeneration					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART I (a) Neurofibromatosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/30 , 19 87 , to 9/5 , 19 87 , that (I) (we) lost saw the deceased alive on 9/5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Giorgio A. Praft		DEGREE MD		22c. DATE SIGNED 9/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GIORGIO A. PRAFT, M.D.		22e. ADDRESS 1404 CRAIN HWY., S., SUITE 300 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 9, 1987		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore City Md.	
24. FUNERAL DIRECTOR NAME R. H. Hadden		ADDRESS Singleton North Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 10 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandey			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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065049 SEP - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified by card.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24857

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZIA C. FORRESTER			2a. DATE OF DEATH MONTH DAY YEAR 8 SEPTEMBER 4 1987		2b. HOUR 12:00 AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8 16 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY AA.	13c. CITY OR TOWN ANNAPOLIS	13d. STREET ADDRESS 105 Northwest Street 21401	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID D. FORRESTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE FORRESTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W.I. 220-16-8072		17. INFORMANT Annapolis, Md. 21401 LOUISE FORRESTER 105 Northwest Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cardiogenic Shock, Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Basant K. Khandelwal		DEGREE M.D.		22c. DATE SIGNED 9/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D.		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND. 21061			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9-4-1987	23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rudner

BP

78 E-932 24020

44

067442 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

William

Foster

8

2- DATE KNOWN OF DEATH
MONTH DAY YEAR
2-27-87
26 HOUR
M

3. SEX

M

4. RACE

B

5. DATE OF BIRTH

6 30 11

6. AGE (IN YEARS)

76 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

9-27-87

2d. HOUR

1:20P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED

WIDOWED

NEVER MARRIED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel County

MD

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

North Arundel Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

MD

13b. COUNTY

BALTO

13c. CITY OR TOWN

Balto city

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2418 E. Fayette St

14. FATHER'S NAME

George

MIDDLE

LAST

Foster

15. MOTHER'S MAIDEN NAME

Kate

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

213-05-5067

17. INFORMANT

Lenida Foster

ADDRESS

2418 E. Fayette St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

10:58PM 9-27-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

pedestrian struck by an auto

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

hwy.

21f. LOCATION

Rt. 2 nr. Shelly Rd. Glen Burnie, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED

9-28-87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10-3-87

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. PK

23d. LOCATION

Balto.

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

Wm. C. BROWN

ADDRESS

1206 W. North Ave

25a. DATE REC'D. BY REGISTRAR

OCT 01 1987

25b. REGISTRAR'S SIGNATURE

Julia Friedman

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

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(VR A15 ME (5))

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RECEIVED

NOV 23 1963

WINTERHART



OCT 14 1963

065085 SEP 9 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24859EDT

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Webster FRAZIER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 4, 1987		2b. HOUR 1110 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 30, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Firefighter		12b. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A A Co. 13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21122 209 North Carolina Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Frazier		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Dunn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1947-1950 220-24-4661		17. INFORMANT (Wife) ADDRESS Dorothy E. Frazier Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Cell Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) metastatic To bone Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Pulmonary Fibrosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 87 , to 9/4 , 19 87 , that (I) (we) lost saw the deceased alive on 9/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mayer Gorbaty		DEGREE M.D.		22c. DATE SIGNED 9/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAYER GORBATY, M.D.		22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 9, 1987	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.	
24. FUNERAL DIRECTOR NAME R. M. Hopkins		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 8 1987	
				25b. REGISTRAR'S SIGNATURE Davidson-Randee	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, which caused or contributed to the death.

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065134 SEP 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC-2 486 EDT

1. DECEASED NAME (TYPE OR PRINT) CHARLES WILLIAM FUNK			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 02, 1987		2b. HOUR 1122 AM	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12 17 17		6. AGE (IN YEARS LAST BIRTHDAY) 69		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3706 ST. MARGARET ST.		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES W. FUNK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HAMILTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW	17. INFORMANT MRS CHARLES FUNK		ADDRESS 3706 ST MARGARET BALTO., MD 21225		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CORONARY ISCHEMIA DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 1982 PRIOS TO 1978						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PREVIOUS MI 7-13-82 HCVD						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this person) attended the deceased from SEPT 2, 1979 to SEPT 2, 1987 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on SEP 02 1987 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>Francis Codd</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-4-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS CODD M.D.		22e. ADDRESS 674 RITCHIE HIGHWAY SEVERNA PARK, MARYLAND 21146				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-5-87	23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME McCully Funeral Home		ADDRESS 237 E. PATAPSCO BALTO., MD 21202		25a. DATE REC'D. BY REGISTRAR SEP 09 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not, any injury, or other traumatic event, the medical examiner should be notified at once.

062134 SEP 10 87

SEPTEMBER 03, 1987 11:15 AM

CHARLES WILLIAM HEN

ANNE ARUNDEL COUNTY

CLIN ILLUMIN NORTH ARUNDEL HOSPITAL

674 RITCHIE HIGHWAY
SEVERNA PARK, MARYLAND 21146

FRANCIS CORP. A.D.

SEP 08 1987

067115 SEP 30 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24861

DECEASED NAME (TYPE OR PRINT) Robert		FIRST Galloway		LAST		20. DATE OF DEATH MONTH 09 DAY 26 YEAR 87		20. HOUR 9:15 P.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 911 Monroe Street 21403	
14. FATHER'S NAME FIRST MACK MIDDLE GALLOWAY LAST				15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE BROWN LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Anna platts, Md. 21403 ROSETTA BROWN 911 Monroe Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant lymphoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 27 , 19 87 , to Sept 26 , 19 87 , that (II) (we) lost saw the deceased alive on Sept 26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS 51 Franklin St. Annapolis, Md. 21034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-1-1987		23c. NAME OF CEMETERY OR CREMATORY CHEWS U.M. CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE Owensville A.A. Maryland			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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065504 SEP 15 87

DIVISION OF VITAL RECORDS-401 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR REGISTERED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	REG. NO. 2-4862	
MARY		TERESA	GAVIN	2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-9-87 19		
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1987 0	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 0 23	IF UNDER 1 YR. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-9-87 19	7d. HOUR 7:58a
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County			
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Crofton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1834 North Forest Court/21114		
14. FATHER'S NAME FIRST MIDDLE LAST John F. Gavin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cynthia M. Rambeau				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS John F. Gavin, Same as # 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant		DATE SIGNED 9-10-87		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, Maryland		
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Rd Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 14 1987		
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

002200 932 402200

0 1891 71 246 2000 1991

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1834 North Tower Court-LLM

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065438 SEP 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3

1. DECEASED NAME (TYPE OR PRINT) MADELINE EUDORA GENTZEL			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 8 1987			2b. HOUR 10:52 AM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 14, 1911	6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 8 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1448 Colony Rd. 21122
14. FATHER'S NAME FIRST MIDDLE LAST Thomas P. Swann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Ralston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 05 0384		17. INFORMANT William B. Gentzel			ADDRESS (Same as 13a-e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) BLUNT CHEST TRAUMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE C. L. Seagen			TITLE (SPECIFY) DEPUTY			DATE SIGNED 9/8/87		
EXAMINER'S NAME (TYPE OR PRINT) CHARLES A. SEAGEN			ADDRESS 780 RITCHIE HWY SV PR MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 12, '87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD		
24. FUNERAL DIRECTOR NAME McCully Funeral Homes			ADDRESS 3204 Mountain Rd. Pasadena, MD 21122			25a. DEPUTY REGISTRAR SEP 14 1987		
						25b. REGISTRAR'S SIGNATURE Julia Benson-Randall		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

062438 SEP 12 84

067103 SEP 29

87-

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4864

1. DECEASED NAME (TYPE OR PRINT) JAMES W GLADDEN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 22, 1987		2b. HOUR 320 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 14, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 7879 Crilly Rd. 21061		14. FATHER'S NAME FIRST MIDDLE LAST Harry R. Gladden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jesse L. Ramsey		16. ADDRESS 214 Circle Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 159-18-8606		17. INFORMANT Marjorie Vondenbosch, Pasadena, MD 21122		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) 2 yr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 87 , to 9/22 , 19 87 , that (I) (we) last saw the deceased alive on 9/22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DR. DAVID A. SCHWARTZ						22c. DATE SIGNED 9/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DAVID A. SCHWARTZ		22e. ADDRESS 7845 OAKWOOD ROAD #200 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25 Sept. 87		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD 21061				25a. DATE REC'D. BY REGISTRAR SEP 28 1987			
25b. REGISTRAR'S SIGNATURE John Davidson							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please reinsert carbonized pages 1 and 2 and fill with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082103 SEP 28 91

SEP 28 1991

SEP 28 1991

066103 SEP 18 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24865

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine B. Glover			2a. DATE OF DEATH MONTH DAY YEAR 09-12-87			2b. HOUR MIN. AM PM 5:00 A					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01-23-15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Insurance			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY New Hampshire Hillsboro			13c. CITY OR TOWN Nashua		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 37-B Manchester Street				
14. FATHER'S NAME FIRST MIDDLE LAST Francis Mc Morrow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen McWeeny			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 625-07-3246		
17. INFORMANT ADDRESS Same as #13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Yes. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 9/11 , 19 87 , to 9/12 , 19 87 , that (I) (we) first saw the deceased alive on 9/11/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE General Abel			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/13/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD ABEL			22e. ADDRESS 8 EMBLETON RD SEVENBOLD PARK MD 21146								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sep 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Sutland P.G. MD				
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD						25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000103 SEP 18 87

Phone Number

Address

City

State

Zip

Country

Telephone

Telex

Fax

E-mail

Web

Other

Comments

Signature

Date

Initials

Print Name

065439 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24866

EDT

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ELLA MAY				GOEHRING	SEPTEMBER 10 1987	4:33 AM
3. SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
FEMALE	CAUCASIAN		11 6 29		57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	USA				ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		HOUSEWIFE			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD	A.A.	PASADENA			13e. STREET ADDRESS 855 Woods RD 21122	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
CHARLES		STRECKER		AMELLA KOHLHOFF		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic cirrhosis</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 85</u> to <u>Sept 11 1987</u> that (I) (we) last saw the deceased alive on <u>Sept 9 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.		22b. SIGNATURE <u>James J. Benjamin, M.D.</u>		22c. DATE SIGNED <u>9/10/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE		
JAMES J. BENJAMIN, M.D.		653 OLD MILL ROAD, MILLERSVILLE, MARYLAND 21108				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL	9-12-87	GLEN HAVEN	BALTIMORE MD			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
McCully Funeral Home		3304 MOUNTAIN RD PASADENA 21122		SEP 14 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

082438 SEP 12 81

20% COLUMBIAN

RECORD

RECORD

RECORD

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

066116 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24867

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET A. GOOB			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11, 1987		2b. HOUR MIN 11:06		
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 7-14-1892		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Millersville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 8330 Woodland Rd. / 21108			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Coughlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-38-3877		17. INFORMANT ADDRESS Margaret MacIntosh (Same as # 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis DUE TO, OR AS A CONSEQUENCE OF (b) bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) advanced age / debilitation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a multiple decubitus ulcers / hypoalbuminemia							
19a. DATE OF OPERATION Sept 26 1986		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED multiple decubitus ulcers / hypoalbuminemia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3708 MOUNTAIN ROAD PASADENA, MARYLAND 21122			
22a. I certify that (I) (this hospital) attended the deceased from Sept 26 1986 to Sept 11 1987 , that (I) (we) last saw the deceased alive on Sept 11 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerry D. Skarbek, M.D.				DEGREE M.D.		22c. DATE SIGNED 9-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY SKARBK, M.D.				22e. ADDRESS 3708 MOUNTAIN ROAD PASADENA, MARYLAND 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-12-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Westview, Balto., MD	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO SEVERNA PARK, MD. 21146				25a. DATE REC'D. BY REGISTRAR SEP 17 1987			
25b. REGISTRAR'S SIGNATURE Julia Bender-Rudolph							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 192 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

066449 SEP 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24868

1. DECEASED NAME (TYPE OR PRINT) William EARL Gorham			2a. DATE OF DEATH MONTH 9 DAY 16 YEAR 87		2b. HOUR 200 P		
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH 6 DAY 8 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNAPOLIS MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Fed. Emp.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN BRADYSIDE		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1769 Cedarhurst Rd. 20764			
14. FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST LUCILLE MIDDLE GORHAM LAST GORHAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 111-11-1244-164342		17. INFORMANT HELEN GORHAM SAME AS 13E		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette Smoking. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 13E							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCT 76 , 19 76 , to 9/16 , 19 87 , that (I) (we) lost saw the deceased alive on 9/16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Harvey J. Steinfield		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY J. STEINFELD		22e. ADDRESS BRADYSIDE MD 20867					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Sept. 19-87		23c. NAME OF CEMETERY OR CREMATORY LAKE MONT		23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE A.A. MD	
24. FUNERAL DIRECTOR NAME C. L. Hicks III ADDRESS ANNAPOLIS-MD. 21401		25a. DATE REC'D. BY CLERK (R.S. REGISTRATION CLERK) SEP 21 1987		25b. SIGNATURE OF CLERK John Davidson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065531 SEP 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is to be retained by the funeral director. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21b showing injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24869

1. DECEASED NAME (TYPE OR PRINT) TERESA Irene			FIRST MIDDLE LAST Gray			2a. DATE OF DEATH MONTH DAY YEAR 8 9 1987				2b. HOUR M		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 8 1962		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN LOTHIAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5051 Solomons Island Rd. 20711			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MAGRUDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE SWANN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Lothian, Md. 20711 MILTON GRAY 5051 Solomons Island Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE H.D. Goldstein						DEGREE			22c. DATE SIGNED 9/8/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.D. Goldstein						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 9-11-1987		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CHURCH CEME.			23d. LOCATION CITY OR TOWN COUNTY STATE Lothian A.A. Maryland				
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR SEP 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

062731 SEP 12 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

065376 SEP 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen A. Grell		2a. DATE OF DEATH MONTH DAY YEAR SEPT 9 1987		2b. HOUR 7 30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		10. CITY OR TOWN OF DEATH Gibson Island		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Broadwater Way	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STREET ADDRESS / ZIP CODE Broadwater Way 21056	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Gibson Isl.	
14. FATHER'S NAME FIRST MIDDLE LAST Herman F. Busch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
16b. SOCIAL SECURITY NO. 218-46-0602		17. INFORMANT Helen K. Wasser, same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the hospital) attended the deceased from <u>1961</u> , 19____, to <u>1987</u> , 19____, that (I) (we) lost saw the deceased alive on <u>9-8-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Arthur Lankford Jr. M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR LANKFORD, JR. M.D.		22e. ADDRESS 2934 MT. RD. PASADENA, MD 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10 Sept. 87		23c. NAME OF CEMETERY OR CREMATORY Security Process	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. MD		24. FUNERAL DIRECTOR NAME James S. Kirkley 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
25a. DATE REC'D. BY REGISTRAR SEP 10 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

062378 SEP 14 87

BY STATE OF NEW YORK

IN SENATE
January 14, 1887
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1886

ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS
1887

NEW YORK:
J. B. LIPPINCOTT & CO. PRINTERS
1887

066319 SEP 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24871

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) LAWRENCE K. GRIFFIN, SR.			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 17 1987		2b. HOUR 4:43 PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 23 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Plumbing		
13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GERALD GRIFFIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL REINHART					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11		17. INFORMANT Linthicum, Maryland 21090 Eva B. Griffin 401 Viewing Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>87</u> , to <u>9-17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Sang C. DoH</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-18-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.				22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/21/87		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vets		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. MD		
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md 21061				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 21 1987 <u>J. L. Davidson</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then these separate carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

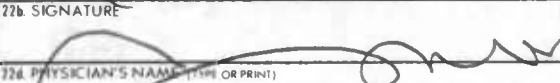
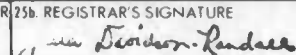
10 33 32 01 30 31

SEP 21 1951

065087 SEP-9

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24872

1. DECEASED NAME (TYPE OR PRINT) LLOYD Edward GRIGGS			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 3, 1987		2b. HOUR 4:31 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 7 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (RET.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Ice Cream Store
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY AA Co.	13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Addison Griggs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Frace		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 153.16.3910		17. INFORMANT ADDRESS Mrs. Ann C. Griggs (wife) same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale and congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 16, 1987 to Sept 3, 1987 , that (I) (we) last saw the deceased alive on Sept 3, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE CHARLES J. WU, M.D.		22c. DATE SIGNED Sept. 3, 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE September 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Atlantic View Cemetery, Manasquan, Monmouth, New Jersey	
24. FUNERAL DIRECTOR NAME C. H. R. R. R.		ADDRESS Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR SEP 8 1987	
		25b. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be circulated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certificate to page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082085 25-381

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

APR 11 1964

COMMUNICATIONS SECTION

065825 SEP 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24873

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
David		Harry		GUINN		September 11, 1987		2:05 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
male		white		Nov 8, 1941		45		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Kentucky		USA				AA Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		North Arundel Hosp.		Fed. Highways		Civil Services			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		501 Short Curve Rd, 21061	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		yes		58 - 79		Faye M. Guinn (wife) same as 13	
(UNKNOWN)		GUINN		Wanda		Bertram			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		b. DUE TO, OR AS A CONSEQUENCE OF		c. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Left ventricular failure		Acute Myocardial infarction		Hypertensive Cardiovascular disease		minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22. I certify that (I) (this hospital) attended the deceased from 9/11/87 to 9/11/87, that (I) (we) last saw the deceased alive on 9/11/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
MAX C FRANK MD		MD		9/12/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. DATE REC'D. BY REGISTRAR		23b. REGISTRAR'S SIGNATURE			
MAX C FRANK MD		2575 Ritchie Hwy - Glen Burnie MD 21061		SEP 15 1987		Julia Davidson-Randall			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Cremation		12 Sept. 1987		Security Process Inc.		Catonsville, Balt.		MD	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home, Glen Burnie, MD						SEP 15 1987		Julia Davidson-Randall	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, a medical examination may be beneficial to the family.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

082852 SEP 12 81

NOTION 202

066569 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24874

1. DECEASED NAME (TYPE OR PRINT) WILLIAM ARTHUR HAIGIS JR			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 17, 1987		2b. HOUR 625 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 3, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Agent	12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21226 4805 Pennington Ave.,
14. FATHER'S NAME FIRST William MIDDLE Arthur LAST Haigis, Sr.		15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE B. LAST Stahl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 216-18-4742	17. INFORMANT 7105 Renwick Ct., Glen Burnie William A. Haigis, III MD. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE ANTEROLATERAL MYOCARDIAL INFARCTION</u>					24 hours
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>September 16, 1987</u> to <u>September 17, 1987</u> , that (I) (we) last saw the deceased alive on <u>September 17, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE <u>Marc Okun MD</u>		DEGREE		22c. DATE SIGNED 9/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC OKUN, M.D.		22e. ADDRESS 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/21/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md. 21225		237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR SEP 22 1987	
				25b. REGISTRAR'S SIGNATURE <u>James Robert R. R. R.</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR		REG. NO. 24875							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Beatrice HALL				2a. DATE OF DEATH MONTH DAY YEAR Sept 26 1987		2b. HOUR P.M.			
3. SEX F		4. RACE B.		5. DATE OF BIRTH MONTH DAY YEAR Sept 14 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 82 2 4		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.		MD	
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 112 Indian Landing Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospt			
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 112 Indian Landing Rd 21108	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas HALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Chapman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-14-9261		17. INFORMANT Margaret Phillips		ADDRESS 1119 Indian Landing			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, Congestive Heart Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE MD				22c. DATE SIGNED 9/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDEWALA MD				22e. ADDRESS 7422 Baltimore Annapolis Blvd Glen Burnie, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Oct 4 1987		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD			
24. FUNERAL DIRECTOR NAME C.E. Hicks				1922 Forest Drive		25a. DATE REC'D BY REGISTRAR OCT 02 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

RECEIVED OCT 20 201

067412 OCT-287

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24819

ED

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DOROTHY		S		HARDY	SEPTEMBER 27, 1987					225 M PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		August 30, 1917		70 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Housewife		Home Maker			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		A.A.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		122 Jack Pine Drive 21122			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Herman Mattes		FIRST MIDDLE LAST Caroline Sarnecka									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		213-20-2858		Dawn Rowe		Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9.6. 1987 to 9.27 1987, that (I) (we) lost saw the deceased alive on 9.22 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9.28.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
SACIT EREN, M.D.					518 SOUTH CAMP MEADE ROAD LINTHICUM, MARYLAND 21090						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY			
Burial		9/30/87		Glen Haven Memorial Pk		Glen Burnie		A.A. Md			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George J. Gonca 4001 Ritchie Hwy Balto Md						OCT - 1 1987		Julia Benson-Rodgers			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

067115 OCT-50

WEST VIRGINIA
WEST VIRGINIA

RECEIVED
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064791 SEP 14 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24877

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hattie Grace Harris			2a. DATE OF DEATH MONTH DAY YEAR September 1, 1987		2b. HOUR 9:15 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 289 Thelma Avenue 21061
14. FATHER'S NAME FIRST MIDDLE LAST William Gibson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Fansler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A	
16b. SOCIAL SECURITY NO. 232.50.8656A		17. INFORMANT (Son) William B. Harris		ADDRESS 5906 Medora Road Linthicum, Md. 21090	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract infection and</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>87</u> , to <u>9/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> , 19 <u>87</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas		22e. ADDRESS 1521 Ritchie Hwy Arnold, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 4, 1987	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR SEP 3 1987	25b. REGISTRAR'S SIGNATURE Julia Anderson-Pandora

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

064720 125420 932-478

064976 SEP-9 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24878

1. DECEASED NAME (TYPE OR PRINT) ELISE POTTER HART			2a. DATE OF DEATH MONTH 9 DAY 6 YEAR 87			2b. HOUR 10³⁰ AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH March DAY 17 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70		7. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co.			MD.	
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Conval. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1624 Dryden Way 21114		
14. FATHER'S NAME FIRST William MIDDLE Richard LAST Potter				15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE Miller LAST Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212,10,8199		17. INFORMANT Paul R. Potter 9612 Cross Road Perry Hall, Md. 21128						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic disease of coronary arteries DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/6/87 to 9/6/87 , that (I) (we) lost saw the deceased alive on 9/6/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE MAX C FRANK MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD				22e. ADDRESS 7515 Ritchie Hwy - Green Broom MD 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9/7/1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR Walter Brooks Bradley Inc. Dundalk, Md. 21222						25a. DATE REC'D. BY REGISTRAR SEP 08 1987		25b. REGISTRAR'S SIGNATURE John A. Jordan		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 when any injury, or other traumatic event, the medical examiner must be notified of once.

BP _____

084218 SEP-2881

20% COLLOIDAL

SEP 28 1981

064927 SEP-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 24819

1. DECEASED NAME (TYPE OR PRINT) Jerome R. Hazleton			2a. DATE OF DEATH MONTH DAY YEAR 9-1-87		2b. HOUR 12:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-25-26		6. AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Operator	12b. KIND OF BUSINESS OR INDUSTRY Auto Service	
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3108 Landfall Lane 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Frank D. Hazleton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luella Amman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 579-249993		17. INFORMANT Dorothy L. Hazleton - #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Bladder Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/30 87 9/1 87	
22a. I certify that (I) (this hospital) attended the deceased from 8/30 87 to 9/1 87 , that (I) (we) last saw the deceased alive on 8/31 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death.					
22b. SIGNATURE E. W. Cole III		DEGREE MD		22c. DATE SIGNED 9/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE III		22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Sept. 1, 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Southland PG MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR SEP 04 1987	
				25b. REGISTRAR'S SIGNATURE J. B. Borden	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

064927 SEP-88

SEP04 1988

065818 SEP 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2408

EDT

1. DECEASED NAME (TYPE OR PRINT) CLARENCE FRANKLIN HEWSON			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13, 1987		2b. HOUR 9:58 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 26, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stove Mounter		12b. KIND OF BUSINESS OR INDUSTRY Stove Mfg.
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Hewson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy		16. STREET ADDRESS / ZIP CODE 5 Glenmont Avenue 21061		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 217.01.6451		17. INFORMANT (Wife) Anita E. Hewson		ADDRESS Same as #13
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Large Cell DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF amaul fibrillation (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-5 19 87 to 9-13 19 87 that (we) lost saw the deceased alive on 9-13 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE D. SAWHNEY				22c. DATE SIGNED 9/14/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SAWHNEY
22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061				22f. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A A Co. Maryland
24. FUNERAL DIRECTOR NAME R. A. Harkin				25a. DATE REC'D. BY REGISTRAR SEP 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
24. FUNERAL HOME Singleton Funeral Home				24. CITY OR TOWN Glen Burnie, Maryland		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove burial-transit permit, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

062818 SEP 18 87



RECEIVED

UNITED STATES

100 51 32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Louise LAST HOGAN			2a. DATE OF DEATH MONTH DAY YEAR September 15, 1987		2b. HOUR P 12:56 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 31 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Lee Scanlon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Louise Parson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	
17. INFORMANT (Husband) Mr. Robert A. Hogan, Jr.		18. ADDRESS Same as #13		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Blon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-15-87</u> to <u>9-15-87</u> , that (I) (we) lost saw the deceased alive on <u>9-15-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>[Signature]</u> DEGREE MD.		22c. DATE SIGNED 9-15-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A.Co. Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS 300 HOSPITAL DRIVE #230 GLEN BURNIE, MARYLAND 21061	

The first part of the report
 deals with the general situation
 and the results of the survey.
 The second part of the report
 deals with the details of the survey.
 The third part of the report
 deals with the conclusions of the survey.
 The fourth part of the report
 deals with the recommendations of the survey.
 The fifth part of the report
 deals with the summary of the survey.

The first part of the report
 deals with the general situation
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 deals with the details of the survey.
 The third part of the report
 deals with the conclusions of the survey.
 The fourth part of the report
 deals with the recommendations of the survey.
 The fifth part of the report
 deals with the summary of the survey.

067299 OCT-1-87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 & 2) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)		FIRST George		MIDDLE C		LAST Holdsworth		20. DATE OF DEATH MONTH DAY YEAR 9 28 87		2b. HOUR 9:10 A M	
3 SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 1 12 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Signalman		12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Odneton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2851 5th Avenue 21113			
14. FATHER'S NAME FIRST MIDDLE LAST George Malcom Holdsworth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Crozier		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-05-7382		17. INFORMANT ADDRESS Glenn R. Srock 611 Orpington Road 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the (2) lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent Pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malignant 2° to #1</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months		2 months		2 months					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Severe emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>12 June</u> 19 <u>87</u> to <u>Sept 28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gary M. Richardson, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-28-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. RICHARDSON, M.D.		22e. ADDRESS 104 Forbes Street Annapolis, Md 21401									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-29-87		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Cremation Society of Md. Inc.		ADDRESS Balto. Md.		25a. DATE REC'D. BY REGISTRAR SEP 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandey					

BP

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Item 5, Film G632 10-23-87 dw

1 - STATE
FOR
REGISTRAR

per funeral home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24883

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Harold</u> MIDDLE <u>Aldridge</u> LAST <u>Horney</u>		2a. DATE OF DEATH MONTH <u>9</u> DAY <u>16</u> YEAR <u>1987</u>		2b. HOUR <u>6:30</u> AM	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>2</u> YEAR <u>1916</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel County</u> MD.		10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Arundel General Hospital</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Diesel Mechanic</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Q.A.</u>		13c. CITY OR TOWN <u>Queenstown</u>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>Box 148, 1st Street</u>		21658	
14. FATHER'S NAME FIRST <u>Aldridge</u> MIDDLE <u>Calvin</u> LAST <u>Horney</u>		15. MOTHER'S MAIDEN NAME FIRST <u>May</u> MIDDLE <u>Pinder</u> LAST <u> </u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>218-09-7634</u>		17. INFORMANT ADDRESS <u>Queenstown, MD</u> <u>Donald Horney, Box 102, Center St., 21658</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant Cancer from Unknown Primary</u> month's DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Wk.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Aspiratory Failure, Gramia, COPD</u>					
19a. DATE OF OPERATION <u>9/16/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u> </u> 19 <u> </u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>9/16/87</u> , 19 <u> </u> , to <u>9/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/16</u> , 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard Colgan</u>		DEGREE <u> </u>		22c. DATE SIGNED <u>9/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard Colgan</u>		22e. ADDRESS <u>703 Giddings Avenue Annapolis, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>09-18-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Easton Talbot MD</u>					
24. FUNERAL DIRECTOR NAME <u>Tom Helfenbein Funeral Home, Chester, MD 21619</u>		ADDRESS <u> </u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 21 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies, Pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 1 2 4 8 8 4

1. DECEASED NAME (PLEASE PRINT) FIRST MIDDLE LAST FRANKLIN R. Horstman			2a. DATE OF DEATH MONTH DAY YEAR 09-16-87			2b. HOUR 3 45 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 27 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rtd. Tractor		12b. KIND OF BUSINESS OR INDUSTRY Gov't.	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 301 Wilmer Place		13f. ZIP CODE 21037		14. FATHER'S NAME FIRST MIDDLE LAST James W. Horstman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Campbell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WA 1		17. INFORMANT ADDRESS Beatrice E. Horstman #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Melanotic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/15 19 87 , to 9/16 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) saw (I) did not see (I) did not view the body after death.							
22b. SIGNATURE Paul Perez		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Perez MD		22e. ADDRESS 1655 Crofton Blvd Crofton MD					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-19-87		23c. NAME OF CEMETERY OR CREMATORY Lakemont		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville A.A. Md.	
24. FUNERAL DIRECTOR Taylor Funeral Chapel		ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Richard S. Howison						2a. DATE OF DEATH MONTH 9 DAY 27 YEAR 1987		2b. HOUR 0537M	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 1 DAY 22 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales/Service		12b. KIND OF BUSINESS OR INDUSTRY X-Ray	
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 468 Broadwater Rd 21012	
14. FATHER'S NAME FIRST Raynor MIDDLE LAST Howison				15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE LAST Schrenker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Mary Howison (Same as # 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION 9/27/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/27 , 19 87 , to 9/27 , 19 87 , that (I) (we) lost saw the deceased alive on 9/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David C Green MD						DEGREE MD		22c. DATE SIGNED 9/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David C Green MD						22e. ADDRESS 706 Giddings Ave Annapolis MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-30-87		23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A., MD			
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO ADDRESS SEVERNA PARK, MD. 21146						25a. DATE REC'D. BY REGISTRAR OCT 05 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 4 8 8 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy Mae Hunt			2a. DATE OF DEATH MONTH DAY YEAR September 18, 1987			2b. HOUR 2 PM M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 28 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6664 Shelly Road Apt C40				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Stuteman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice LaDemia Mack		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-28-2126	
17. INFORMANT ADDRESS 21225		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis of the coronary arteries</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> <u>10 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1972</u> 19____, to <u>9/18/87</u> 19____, that (I) (we) last saw the deceased alive on <u>8/2/87</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. Munies</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Doctor Silvino B. Munies MD		22e. ADDRESS 3721 Potee Street Baltimore Maryland 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/21/1987		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md	
24. FUNERAL DIRECTOR NAME Geo. F. Gonce F.H.		ADDRESS 4001 Ritchie Hwy 21225		25a. DATE REC'D. BY REGISTRAR SEP 22 1987		25b. REGISTRAR'S SIGNATURE <u>J. Anderson</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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SEP 23 1967

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4887

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy B. HUNTER		2a. DATE OF DEATH MONTH DAY YEAR SEPT 30, 1987		2b. HOUR 12 30A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 28 1894	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONV. CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	
13a. STATE MD.		13b. COUNTY AA.		13c. CITY OR TOWN ANNAPOLIS	
14. FATHER'S NAME FIRST MIDDLE LAST William Hunter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE COCKBURN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 192-05-5276		17. INFORMANT DOUGLAS H JOHN		ADDRESS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Chronic debility of old age DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 days years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) dementia due to Alzheimer's disease.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Jan 87 to Present 19 87 , that (I) (we) last saw the deceased alive on 9/23/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Peter F. Verkouw		DEGREE		22c. DATE SIGNED 9/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW		22e. ADDRESS 1833 FOREST DR ANNAPOLIS MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9/30/87		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM	
23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MD		25a. DATE REC'D. BY REGISTRAR OCT 1 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel Annapolis MD					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 3 of 30

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066595 SEP 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4383 EDT

1. DECEASED NAME (TYPE OR PRINT) ROBERT FRANCIS HUSTER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 22, 1987		2b. HOUR 1220 AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YR 6 24 17	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Transportation
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT A. HUSTER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE M. MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11	17. INFORMANT Glen Burnie, Maryland 21061 Mary T. Huster 55 Mapledale Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Intracranial Hemorrhage</u> (c) <u>Hypertensive Crisis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> 19 <u>87</u> to <u>9/21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>9/22/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL J. YOUNG-HYMAN, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/25/87	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md	
24. FUNERAL DIRECTOR NAME Raymond C. Fink		ADDRESS Glen Burnie, Md. 21061		25a. DATE REC'D. BY REGISTRAR SEP 23 1987	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SEP 23 1961

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24889

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha B Jefferies			2a. DATE OF DEATH MONTH DAY YEAR 9-06-87		2b. HOUR 4:20 A		
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 11 14 38		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Grove City, Pa.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY A.A. County	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William g. Cooke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mildred E. Braham					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 181-30-4403		17. INFORMANT ADDRESS Mr. Larry D. Jefferies (same as 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/30, 19 87, to 9/6, 19 87, that (I) (we) last saw the deceased alive on 9/5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart E. Selonick, M.D.		DEGREE ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.		22e. ADDRESS 51 Franklin street, Annapolis 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-9-1987		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION Crownsville A.A. Md.	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		ADDRESS SEVERNA PARK, MD. 21146		25a. DATE REC'D. BY REGISTRAR SEP 15 1987		25b. REGISTRAR'S SIGNATURE Julia Dendron-Rudner	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

066899

SEP 24 1987

066584 SEP 28 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2439 UEDT

1. DECEASED NAME (TYPE OR PRINT) BESSIE H. JENKINS			20. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 19, 1987		21. HOUR 1140 AM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12-26-1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		13a. STREET ADDRESS 7657 MARCY COURT	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN GLEN BURNIE		13d. STATE MD.	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE H. GROSS SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA KLUPP		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 212-42-6205		17. INFORMANT ADDRESS Joseph B. Amrhein - 7657 Marcy Court		21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF AS HD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe DUE TO, OR AS A CONSEQUENCE OF acute UT failure (c) Acute renal failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Diabetes mellitus					
19. DATE OF OPERATION 9/13/87		20. CONDITION FOR WHICH OPERATION WAS PERFORMED Angiogram of R. foot.		21. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. DATE OF INJURY 9/12/87		23. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		24. HOW INJURY OCCURRED (ENTER IN DETAIL IN ITEM 18, PART 1, OR PART 2) Spontaneous pericardial tamponade	
25. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		26. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		27. LOCATION STREET CITY OR TOWN COUNTY STATE Sept. 19, 1987	
28. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1987 to Sept. 19, 1987 , that (I) (we) lost the deceased alive on Sept. 19, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
29. SIGNATURE Benjamin de Guzman, M.D.		30. DEGREE M.D.		31. DATE SIGNED Sept. 19, 1987	
32. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. DEGUZMAN, M. D.		33. ADDRESS 325 HOSPITAL DRIVE, SUITE 108		34. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE, MARYLAND 21061	
35. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		36. DATE 9-22-87		37. NAME OF CEMETERY OR CREMATORY MORELAND MEM.	
38. FUNERAL DIRECTOR NAME Jantha Apple - 7527 Harford Rd.		39. ADDRESS SEP 22 1987		40. REGISTRAR'S SIGNATURE Julia Friedman-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a police report filed.

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065381 SEP 14 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24691

1. DECEASED NAME (TYPE OR PRINT) Sydney H. Kane			2a. DATE OF DEATH MONTH DAY YEAR 09 07 87			2b. HOUR 1055 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 2, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Physician	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Manuel Kane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Reba Heller		16. STREET ADDRESS / ZIP CODE 844 Deerwood Court 21401					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 201-34-0875		17. INFORMANT Emma B. Kane		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Coriary poly (old mg) DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Lower BS blood, hyperlipid									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/5 19 87 , to present 19 87 , that (I) (we) lost saw the deceased alive on 9/5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Biern				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/8	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Biern, MD				22e. ADDRESS 51 Franklin St. Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sep 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR SEP 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudolph			

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 14th of September
 1981 at the residence of
 Mr. J. H. Smith, 123
 Main Street, New York
 City. The names are listed
 in alphabetical order.

067284 OCT-187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24892

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH Franklin KAYLOR				2a. DATE OF DEATH MONTH DAY YEAR 9 26 87				2b. HOUR 10¹⁰ A.M.	
3. SEX Male		4. RACE White-Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 6 25 02		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greensburg, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 936 Tidewater Grove Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conservationist		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 936 Tidewater Grove Ct. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Kaylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecile Shoemaker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-36-8702		17. INFORMANT Fadre Kaylor		ADDRESS 936 Tidewater Grove Ct 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/1 87 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) 8/1 87		21f. LOCATION STREET 9/26 87		CITY OR TOWN Frederick Co., Md.		STATE Md.	
22a. I certify that (1) (this hospital) attended the deceased from 9/1 87 to 9/26 87 , that (1) (we) last saw the deceased alive on above (1) (we) (did) (did not) view the body after death. 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE E W Cole III				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III				22e. ADDRESS 51 FRANKLIN ST ANNAP MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial of ashes		23b. DATE Oct. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Baptist Conv. of Md.		23d. LOCATION CITY OR TOWN Baltimore City, Md.		23e. NAME OF CEMETERY OR CREMATORY Greenmount Cem. Crem.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Rd. Bal. Md. 21212		25a. DATE REC'D. BY REGISTRAR SEP 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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067155 SEP '87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24890

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE R. KOSTKOWSKI			2a. DATE OF DEATH, MONTH DAY YEAR 9/27/87			2b. HOUR M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 - 8 - 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Household		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY A. Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1751 Dunton Rd. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Beyma			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wiechorek			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 212094849			17. INFORMANT ADDRESS Clifford Riggins Annapolis, MD. 21401							
18. CAUSE OF DEATH (Enter only one cause per line for each 1a, and 1b) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 1 mo										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11c										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 9/31/75 , 19 87 , to 9/27/87 , 19 87 , that (I) (we) lost saw the deceased alive on 9/27/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Richard I. Hochman						DEGREE M.D.		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard I. Hochman M.D.						22e. ADDRESS 16 Murray Ave Annapolis, MD 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/30/87		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville AA Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home, Annapolis, Md.						25a. DATE REC'D. BY REGISTRAR 9-30-87		25b. REGISTRAR'S SIGNATURE		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, a medical examiner must be notified at once.

001122 SEP 30 01

NOTICE

NOTICE

NOTICE



065585 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24894

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE OF DEATH			2d. HOUR		
Helen C. Krolicki			9 8 1987			9 8 1987			9 8 1987			1120		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS	9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		
F	Can	8 25 62	62 YRS.			Anne Arundel County			Annapolis			Anne Arundel Gen		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Pennsylvania			USA						Anne Arundel County			Annapolis		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Kitchen Helper			Restaurant			Md			AA			Harwood		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Stephen			Catherine Duanye			No			183 26 4013			Robert E Krolicki Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						HOUR A.M. MONTH DAY YEAR		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			CITY OR TOWN		
									STREET			COUNTY		
									STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
William P. Jones			M.D. Deputy			9/8/87			Burial			11 Sept 87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN		
William P. Jones, MD			695 America Crt Davidsonville, Md. 21035			Resurrection Cem			Clinton			Maryland		
24. FUNERAL DIRECTOR			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			26. NAME			ADDRESS		
Robert E Wilhelm Funeral Home			SEP 14 1987			Julia Davidson-Randall			Suitland			Maryland		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, AND 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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NOTION 202



Hyper-tension

4/2/53

Walter J. Jones, M.D.

SEP 1 1953

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24895

1. DECEASED NAME (TYPE OR PRINT) MARION JAMES KUCZINSKI			2a. DATE OF DEATH MONTH DAY YEAR September 8, 1987		2b. HOUR MIN. 2:45 P
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 23, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co. MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Const. Sup't.		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 787 JENNIE DRIVE 21144
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Kuczinski, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Andrews		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 212.30.5990		17. INFORMANT (Wife) ADDRESS Mrs. Anna Mae Kuczinski (Same as #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INTRACRANIAL HEMORRHAGE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS.
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/8 87 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (a) (this hospital) attended the deceased from 9/8 87 to 9/8 87 , that (b) (we) lost saw the deceased alive on 9/8 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Robert S. Eden, M.D.		DEGREE M.D.		22c. DATE SIGNED 9/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert S. Eden M.D.		22e. ADDRESS Franklin & Cathedral Sts. Annapolis, Md. 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 10 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudolph	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24890

1. STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		2c. HOUR	
FOR		HERMINE Leingstaetter		09-16-87		5:05 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		June 8, 1896		91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Austria		Austria				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hospital		Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		AA		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
				No		217-52-4093A	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Same as #13		IMMEDIATE CAUSE (a) Cardio respiratory arrest				0	
		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic illness & malnutrition				> 2 months	
		DUE TO, OR AS A CONSEQUENCE OF (c) CA of Stomach & liver involvement				> 2 month	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
30 Jul 87 31 Aug 87		GASTRIC ULCER R/O CA PLACEMENT FEEDING JEJUNOSTOMY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 16 Jul 19 87, to 16 Sep 19 87, that (I) (we) last saw the deceased alive on 15 Jul 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
[Signature]		MD		16 Sep 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
MOORE ROBERT C		130 Holiday Court Suite 106 Annapolis 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Sep 17, 1987		Hillcrest		Annapolis AA MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Taylor Funeral Chapel - Annapolis, MD		SEP 17 1987		[Signature]			

BP

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(VRA 15, 4)

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65816 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 439

1. DECEASED NAME (TYPE OR PRINT) Charles O. Leitch			2a. DATE OF DEATH MONTH DAY YEAR 9 13 87			2b. HOUR M 11				
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 19 17		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Davidsonville		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 965 Mt. Airy Road 21035	
14. FATHER'S NAME FIRST MIDDLE LAST C. Roland Leitch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen G. Wayson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218129897		17. INFORMANT ADDRESS Frances Rogers #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lung cancer DUE TO, OR AS A CONSEQUENCE OF cigarette use Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) 50 years (c) 1 1/2 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from March 3, 19 87, to March 13, 19 87, that (I) (we) last saw the deceased alive on September 2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/13/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS 57 Franklin St Annapolis, Md. 21014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/87		23c. NAME OF CEMETERY OR CREMATORY Davidsonville UMC		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AA Md.				
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home, Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR SEP 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death, manner of death, and place of death from pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2818 SEP 18 62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit requires carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE RECORDS		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2. DATE OF DEATH	REG. NO.	3. MONTH	4. DAY	5. YEAR	6. HOUR
5065280 SEP 14 1987		SARA W LONERGAN					9-5-87					12:30 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.				
Female	White	3-12-19		68 YRS		MONTHS		DAYS		HOURS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	United States				Anne Arundel County, MD							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis	Anne Arundel General Hospital		Homemaker		Own Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS?	13f. STREET ADDRESS / ZIP CODE							
Maryland	Anne Arundel	Crofton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1719 Granite Court/ 21114								
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Harry T. Wise	Ruby Southworth		No		219-01-3553		Denis L. Murray, Esq. Crofton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS, GI BLEEDING, SHOCK LUNG, ATN</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OVERLAPPING PANCREATITIS</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14/87</u> 19 <u>87</u> , to <u>9/4/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/24/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED				
<u>Carol Pressey</u>		MD						9-5-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
CAROL PRESSEY		3 VILLAGE GREEN, CROFTON, MD,										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		Sept. 8, 1987		Woodlawn Cemetery		Baltimore		Maryland				
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Beall Funeral Home		SEP 09 1987		<u>Julia Davidson</u>								
16000 Annapolis Rd. Bowie, Maryland 20715												

BP _____

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Ann Arbor, Mich.

United States

Michigan

Honorable

James Earl Ray

Ann Arbor

1115 Grand, Grand Rapids

James Earl Ray

Michigan

1115 Grand, Grand Rapids

Only

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James Earl Ray, Grand Rapids, Michigan

1115-11-1115

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SEP 08 1987

10000 Ann Arbor, Mich., Michigan

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SEP 30 87
ST
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

37 REG. NO. 24897

1 DECEASED NAME (TYPE OR PRINT) EMELINE E. LORD			2a DATE OF DEATH MONTH DAY YEAR 9-24-87		2b HOUR 8:30p.m.
3 SEX Female	4 RACE Cau.	5 DATE OF BIRTH MONTH DAY YEAR 6-27-02		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD	
10 CITY OR TOWN OF DEATH Crownsville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Home		12a USUAL OCCUPATION (IF NOT WORKING, GIVE WORKING LIFE) Reg. Nurse		12b KIND OF BUSINESS OR INDUSTRY Therapist Physical
13a STATE Md.	13b COUNTY AACo.	13c CITY OR TOWN Severn	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 7909 S. Cartier Ct. 21144	
14 FATHER'S NAME FIRST MIDDLE LAST James Moriarty		15 MOTHER'S MAIDEN NAME (1951) FIRST MIDDLE LAST Ellen Gilligan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 035-20-8205	17 INFORMANT ADDRESS Elaine Cook Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) <u>Compression of Vertebrae (1 mo ago)</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19 DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>2 Nov 1984</u> to <u>24 Sept 1987</u> , that (I) (we) lost saw the deceased alive on <u>15 Sept 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <u>William P. Jones MD</u>		DEGREE MD		22c DATE SIGNED 9/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, M.D.		22e ADDRESS 4837 Solomons Is. Rd. Iothina, Md. 20711			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 9-28-87	23c NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Odenton AACo. Md.	
24 FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home Annapolis, Md.		25a DATE REC'D BY REGISTRAR 9-28-87		25b REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove complete pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If burial is delayed by 72 hours or other significant event, the medical examiner may be notified.

IMPORTANT: If burial is delayed by 72 hours or other significant event, the medical examiner may be notified.

087127 SEP 30 68



30% COTTON

82 82

Customer Account
W. G. D. D.

100% Cotton (see spec.)

100% Cotton
100% Cotton
100% Cotton

067261 OCT -

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34900

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL Joseph LORENZ			2a. DATE OF DEATH MONTH DAY YEAR SEPT 25 1987		2b. HOUR 7 P M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Nov. 24 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		10. CITY OR TOWN OF DEATH Linthicum		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 536 Forest View Road	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum	
14. FATHER'S NAME FIRST MIDDLE LAST John August Lorenz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agatha Siegwart		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 536 Forest View Road, 21090	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		17b. SOCIAL SECURITY NO. WW II 212-01-3443		17c. INFORMANT Helen Rohleder, 536 Forest View Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR					YRS.
DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPT 13, 1985 to SEPT 25, 1987 that (I) (we) last saw the deceased alive on AUG 15, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. Milton Linthicum M.D.		DEGREE M.D.		22c. DATE SIGNED Sept 25, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. MILTON LINTHICUM, M.D.		22e. ADDRESS 202 W. MAPLE RD LINTHICUM HGTS, MD 21090			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/29/87		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229			
25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must not file a report.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

007581-133 182700

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24901

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM		FIRST Joshua		MIDDLE LOUDENSLAGER		LAST SR		20. DATE OF DEATH SEPTEMBER 26, 1987		21. HOUR 1145 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Oct. DAY 28 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Ret)		12b. KIND OF BUSINESS OR INDUSTRY B & O Rail Road	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 24 Ferndale Avenue 21061			
14. FATHER'S NAME FIRST Herbert MIDDLE B. LAST Loudenslager				15. MOTHER'S MAIDEN NAME FIRST Caroline MIDDLE LAST Heinz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Wife) Georgianna W. Loudenslager		ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-24 , 19 87 , to 9-26 , 19 87 , that (I) (we) lost saw the deceased alive on 9-26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sang C. DoH, M.D.						DEGREE 		22c. DATE SIGNED 9-28-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.						22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland					
24. FUNERAL DIRECTOR NAME H. A. Singleton ADDRESS Singleton Funeral Home Glen Burnie, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

99

BP

067163 SEP 30 83

WILLIAM J. DOUGHERTY JR. SEPTEMBER 15, 1987 11:45 AM

ANNE ARUNDEL COUNTY

CLIN BUNITE NORTH ANNEDEL HOSPITAL

95 ADAMANT ROAD
CLIN BUNITE, MARYLAND 21061

SAUC C. DON, M.D.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4902 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGELINE GERVASI LUCY			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13, 1987		2b. HOUR 9.05 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse	
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rosano		13e. STREET ADDRESS 214 Kent Road		21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT (Daughter) Jacquelyn Lucy		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR STROKE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE ATROCIECTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 HOURS</u> <u>DAYS</u> <u>YEARS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>STATUS POST CARDIOPULMONARY RESUSCITATION</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>9/8/87</u> , 19 <u>87</u> , to <u>9/13/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/13/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE H. D.		22c. DATE SIGNED <u>9/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. DAVID ROSE, M.D.				22e. ADDRESS 200 HOSPITAL DRIVE, SUITE 500 GLEN BURNIE, MD 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.	
24. FUNERAL DIRECTOR NAME R. A. Hyatt				25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia Swickard-Randall	
26. SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND							

48 SEP 18 01

65285 SEP 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha (NMN) Ludwig			2a. DATE OF DEATH MONTH DAY YEAR 9-7-87		2b. HOUR 6³⁵ P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland			13b. COUNTY Pr. George's		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Janovsky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Janacek			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 060-52-5485			17. INFORMANT ADDRESS Evelyn L. Morrison 2701 Enterprise Road Mitchellville, MD 20716					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction or MI			
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Hypertension			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/19/87 , 19 87 , to Sept 7 , 19 87 , that (I) (we) last saw the deceased alive on 9/2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald C. Sroka MD				DEGREE MD		22c. DATE SIGNED 9/7/87 2:48 PM	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD SROKA MD				22e. ADDRESS 3 V. HAGE GREEN CROFTON, MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE SEPT 10, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery East Elmhurst,		23d. LOCATION CITY OR TOWN COUNTY STATE New York	
24. FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home 16000 Annapolis Road Bowie, MD 20715-3043				25a. DATE REC'D. BY REGISTRAR SEP 09 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit may have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR 1587		2a DATE OF DEATH MONTH DAY YEAR 09 30 87		2b HOUR 1 15 AM	
3 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Agnes LUNDGREN		4 SEX Female		4 RACE Cau	
5 DATE OF BIRTH MONTH DAY YEAR 09 12 00		6 AGE (IN YEARS LAST BIRTHDAY) 87		7 BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) RI		9a CITIZEN OF WHAT COUNTRY? USA		9b MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Crofton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Conv. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE VA		13b. COUNTY McLean		13c. CITY OR TOWN McLean	
14 FATHER'S NAME EUGENE SULLIVAN		15 MOTHER'S MAIDEN NAME MARY SULLIVAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 224-76-9780		17. INFORMANT MARY ANN LUNDGREN/7255 MCLEAN COMMONS LANE		18. ADDRESS MCLEAN, VA.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain anoxia DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (c) Hyperkalemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a metastatic breast ca, CHF, renal failure					
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 04-22-87 19 87 to 09-30 19 87 that (I) (we) last saw the deceased alive on 09-29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MAX C FRANK		22c. DEGREE MD		22d. DATE SIGNED 9/30/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK		22f. ADDRESS 7575 Ritchie Hwy Clem Burke MD 21061			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 10/2/87		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VA.		24. FUNERAL DIRECTOR MURPHY FUNERAL HOME/4510 WILSON BLVD. ARLINGTON		25a. DATE REC'D. BY REGISTRAR OCT 02 1987	

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This place is for use only by the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

X

066117 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24905

1. DECEASED NAME (TYPE OR PRINT) WILLIAM F LYNCH			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 15, 1987		2b. HOUR 427 AM										
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09-30-1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.									
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Penn. Central		12b. KIND OF BUSINESS OR INDUSTRY Railroad							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Delaware			13b. COUNTY Sussex		13c. CITY OR TOWN Seaford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8 east High St. Blades						
14. FATHER'S NAME FIRST MIDDLE LAST William F. Lynch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Farrell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 042-16-8076		17. INFORMANT Watson-Yates F.H.		ADDRESS P.O. Box 356 Seaford, Del. 19973	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia, severe 2° & 3°										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiorespiratory arrest										DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c) Cerebral pt. Disease															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHF & Diabetes Mellitus NID															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 9/13 , 19 87 , to 9/15 , 19 87 , that (1) (we) last saw the deceased alive on 9/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (we) (we) did not view the body after death.															
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/18/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTACIO E. SUBONG, M.D.			22e. ADDRESS 4730 MOUNTAIN ROAD PASADENA, MARYLAND 21122												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 09-16-1987			23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balt. Co. Md.						
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO SEVERNA PARK, MD. 21146						25a. DATE REC'D. BY REGISTRAR SEP 17 1987			25b. REGISTRAR'S SIGNATURE [Signature]						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SEVERN PARK, MD 21145
WESLEY B. BARNARD

066600 SEP 24 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24906

1. DECEASED NAME (TYPE OR PRINT) Marion Francis Maka			2a. DATE OF DEATH MONTH DAY YEAR September 21, 1987		2b. HOUR 11:25a
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 2, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Brooklyn Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 Seward Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter	12b. KIND OF BUSINESS OR INDUSTRY Butcher	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Brooklyn Pk.	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Maka			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Grocki		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Mary J. Maka-211 Seward Ave. #21225		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC PROSTATE CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/24/87 to 9/26/87, that (I) (we) last saw the deceased alive above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CARLOS S. 21662		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/22/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/24/87		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.	
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc.		ADDRESS -705 S. Ann St.		25a. DATE REC'D. BY REGISTRAR SEP 23 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assigned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

September 21, 1981

1981

United States Court

San Francisco

Case No. 81-10000

1981

Case No. 81-10000

Case No. 81-10000

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Case No. 81-10000

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1981

Case No. 81-10000

Case No. 81-10000

065783 SEP 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24907

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ann M. Marinoff		2a. DATE OF DEATH MONTH DAY YEAR 9-11-87		2b. HOUR 8:45 A	
3. SEX FEMALE	4. RACE CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR APRIL 20, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MD	13b. COUNTY AA CO	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1960 SIGFRIED CT. 1401	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. BORAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BRILL		ADDRESS 1960 SIGFRID CT. ANNAPOLIS, MD. 21401	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 225-10-1301		17. INFORMANT ALEXIS DORSEY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) arrhythmic DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H.D. Goldstein M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.D. Goldstein M.D.		22e. ADDRESS 205 Ridgely Ave. Annapolis MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/14/87	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA.	
24. FUNERAL DIRECTOR NAME Dwight E. Turner F.H.		ADDRESS ALEX. VA.		25. DATE REC'D BY REGISTRAR SEP 15 1987	

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RECEIVED
SEP 18 1901

SEP 15 1901

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for statistical, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)				3. DATE OF DEATH		REG. NO.	
1507		Margaret V. Martin				9/6/87 9:25 AM		24908	
3. SEX	F	4. RACE	BLACK	5. DATE OF BIRTH	3/16/24	6. AGE (IN YEARS LAST BIRTHDAY)	63	IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	ALABAMA	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH	ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR SERVICE		
		ANNE ARUNDEL GENERAL HOSPITAL			SALES CLERK		SEARS ROEBUCK		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
MARYLAND	AA.	ARNOLD	YES <input type="checkbox"/> NO <input type="checkbox"/>	62 Fox Run Way 21012					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
JOSEPH GOUDY			CARRIE REED						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		419306273		ROBERT MARTIN 62 Fox Run Way Arnold, Md. 21012					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cancer & multiple metastases</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastases</u>								2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
1986		Cancer			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from 9-4-85, 1985, to 9-6-87, 1987, that (I) (me) last saw the deceased alive on 9-8-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE				DEGREE			22c. DATE SIGNED		
Paul Holschuh				MD			9-8-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Holschuh				706 Giddings Ave Annapolis					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		9-11-1987		HILL CREST CEMETERY		Annapolis A.A. Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Annapolis, Md. 21401				SEP 14 1987		Julia Davidson-Randall			
WILLIAM REESE & SONS MORTUARY, P.A.									

BP

067005 SEP 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
<div>FOR STATE REGISTRAR</div> <div>REG. NO. 24909</div>									
<div>DECEASED NAME (TYPE OR PRINT) MICHAEL A. MEALEY III</div>									
<div>2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 24 1987 2b. HOUR 21:46</div>									
<div>1. SEX Male 4. RACE White 5. DATE OF BIRTH Oct. 31, 1959 6. AGE (IN YEARS) 27 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN.</div>									
<div>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware 7b. CITIZEN'S WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD</div>									
<div>10. CITY OR TOWN OF DEATH White Marsh 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 40 East of Jones Rd. 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Student 12b. KIND OF BUSINESS OR INDUSTRY School</div>									
<div>13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Delaware 13c. CITY OR TOWN NEWARK 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 19 DEFOE CIRCLE</div>									
<div>14. FATHER'S NAME FIRST MIDDLE LAST Michael A. Mealey II 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Kelly</div>									
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 221 32 7211 17. INFORMANT ADDRESS Toni M. Mealey Wife Same</div>									
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF (b) MOTOR VEHICLE ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 8199</div>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<div>19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>									
<div>21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)</div>									
<div>21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE</div>									
<div>22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion</div>									
<div>ACTUAL SIGNATURE J M Nietoff TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER DATE SIGNED 9/24/87 BALTO, MD.</div>									
<div>EXAMINER'S NAME (TYPE OR PRINT) J M NIETOFF, MD ADDRESS 9000 FRANKLIN SQUARE APT 21237</div>									
<div>23a. BURIAL, CREMATION, REMOVAL Removal 23b. DATE 9/25/87 23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware</div>									
<div>24. GENERAL DIRECTOR Bruzdinski Funeral Home 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall</div>									

DMH-17
(VR A15 ME (5))

007002 SEP 29 87

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]

[Illegible handwritten notes and stamps]

067026 SEP 29 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24910

EST

DECEASED NAME (TYPE OR PRINT) KENNETH MIDDLE MEYER		2a. DATE OF DEATH MONTH DAY YEAR 8 SEPTEMBER 25, 1987		2b. HOUR 420 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4-11-1920	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OF BIRTH OR DEATH GLEN BORNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST	12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING	
13a. STATE MD.		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN PASADENA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST NICHOLAS MIDDLE MEYER LAST MEYER		15. MOTHER'S MAIDEN NAME FIRST MAY MIDDLE MEYER LAST MEYER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 215-03-0582	17. INFORMANT ADDRESS Mrs. Mary M. Meyer - 669 Riverside Dr. 21122		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) irreversible Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AS HOME, STREET, FACTORY, OFFICE, FARM, ETC.) at Randall M. Chagnon	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from November 9, 1981 to September 25, 1987 , that (I) (we) last saw the deceased alive on July 28, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.				
22b. SIGNATURE Jerry O. Skarbek	DEGREE M.D. FOR R.M. Chagnon	22c. DATE SIGNED 9-25-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY O. SKARBEK, MD	22e. ADDRESS 5708 MOUNTAIN ROAD PASADENA, MARYLAND 21122			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-29-87	23c. NAME OF CEMETERY OR CREMATORY MORELAND CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME Garth Miller - 7527 Harford Rd.		25a. DATE REC'D. BY REGISTRAR SEP 28 1987		
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/BI
(VRA 15, 4)

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WHITE WARDEN INSTITUTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) Schubert R. Meyer		2a. DATE OF DEATH MONTH DAY YEAR September 27, 1987		2b. HOUR 6:00am	
3. SEX Male	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Odenton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1576 Meyer Station Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1576 Meyer Station Rd. / 21113
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Meyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Meyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-18-0266		17. INFORMANT ADDRESS Odenton, Maryland William H. Meyer Sr. 1566 Meyer Station Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL hematoma 9289 DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~19 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Family refused surgery					
19a. DATE OF OPERATION 9/28/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 8		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/16 19 87 , to 9/23 19 87 that (I) (we) lost saw the deceased alive on 9/23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Laurie J. Ross, M.D.		DEGREE MD		22c. DATE SIGNED Sept. 28, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurie J. Ross, M.D.		22e. ADDRESS 1438 Defense Hwy. Gambrills, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1987 Sept. 29,		23c. NAME OF CEMETERY OR CREMATORY First Lutheran Church	
23d. LOCATION CITY OR TOWN COUNTY Bowie, Prince Geo., Maryland					
24. FUNERAL DIRECTOR Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR SEP 30 1987	
		25b. REGISTRAR'S SIGNATURE Julia Tindler-Randall			

065866 SEP 16 87

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4912 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBUR CHESTER MILLER SR			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13, 1987		2b. HOUR 7.35 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR APR 23, 1918		
6. AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 74 HRS HOURS MIN. YRS		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. CITY OR TOWN OF DEATH GLEN BURNIE		13b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		13c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN West Virginia Jefferson Harpers Ferry		
14. FATHER'S NAME FIRST MIDDLE LAST Chester W. Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda G. Stutzka		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
17. STREET ADDRESS Rt # 1 Box 729		18. ZIP CODE 25425		19. PHONE NUMBER 99999		
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		21. SOCIAL SECURITY NO. WW 11 212-14-2828		22. INFORMANT ADDRESS Glen Burnie Md Mrs. Muriel A. Miller 874 Brighton Place		
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. failure, ARDS, Aspiration. DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to lung & liver DUE TO, OR AS A CONSEQUENCE OF (c) ca of esophagus. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. COPD. Hx of stroke.						
24a. DATE OF OPERATION		24b. CONDITION FOR WHICH OPERATION WAS PERFORMED		24c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26c. LOCATION STREET CITY OR TOWN COUNTY STATE		
27a. I certify that (I) (this hospital) attended the deceased from 9-6 , 19 87 , to 9-13 , 19 87 , that (I) (we) last saw the deceased alive on 9-13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
27b. SIGNATURE Shaddy		27c. DEGREE MD		27d. DATE SIGNED 9-14 '87		
27e. PHYSICIAN'S NAME (TYPE OR PRINT) SOPHIA REDDY M.D.		27f. ADDRESS 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061				
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		28b. DATE 9/16/87		28c. NAME OF CEMETERY OR CREMATORY Westview Crematory		
28d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		29. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. 5305 Harford Road 21214				
30. DATE REC'D. BY REGISTRAR SEP 15 1987		31. REGISTRAR'S SIGNATURE Julia Anderson-Randall				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

999999
DHMH-16 50M 1/81
(VRA 15, 4)

082868 SEP 18 87

066102 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24913

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roland R. Most, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 15, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Auditor of MD		12b. KIND OF BUSINESS OR INDUSTRY State
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 46 Summerfield Road 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Most		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Matzell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII		16b. SOCIAL SECURITY NO. 220-05-8181		17. INFORMANT ADDRESS Patricia J. Most Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, organism undet.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent aspiration					3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Multiple cerebral infarctions					undet.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, complete heart block with pre-excitation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) that he attended the deceased from July 8 , 19 87 , to Sept 13 , 19 87 , that (I) we lost saw the deceased alive on Sept 2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles W. Kinzer		DEGREE MD		22c. DATE SIGNED Sep 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, MD		22e. ADDRESS Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Sept 14, 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P-C MD	
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, all other traumatic events, medical conditions, or other factors must be noted in the space provided.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

I have the honor to acknowledge the receipt of your letter of the 15th inst. in relation to the above matter. I am sorry to hear that you are unable to visit the place at the present time. I will be glad to have you call on me when you are able to do so. I am, Sir, very respectfully,
 Yours truly,
 J. M. Smith

I have the honor to acknowledge the receipt of your letter of the 15th inst. in relation to the above matter. I am sorry to hear that you are unable to visit the place at the present time. I will be glad to have you call on me when you are able to do so. I am, Sir, very respectfully,
 Yours truly,
 J. M. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24914DT

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FREDERICK WALTER MURRAY SR		26 DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24, 1987		26 HOUR 819 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 8 1950	6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Fitter	12b. KIND OF BUSINESS OR INDUSTRY Local #438		
13a. STATE Maryland		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Silas Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada C. Moyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT (Wife) Dawn Murray Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Idiopathic Hypertrophic Subaortic Stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 + years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>NONE</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> 19 <u>84</u> , to <u>Sept</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Sept 21</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ronald E. Gillilan M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/24/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD GILLILAN M.D.		22e. ADDRESS 900 CATON AVENUE BALTIMORE, MARYLAND 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE <u>Sept 26 1987</u>	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Maryland		
24. FUNERAL DIRECTOR <u>Singleton Funeral Home, Glen Burnie, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

007128 SEP 30 68

CLAY PIERCE NORTH BRIDGE HOSPITAL

JOHN WILLIAM M.D.
SALT LAKE CITY, UTAH

066571 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 2491
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
SEPTEMBER 20, 1987 915 PM1. DECEASED NAME FIRST MIDDLE LAST
CLARA ESTELLA NAUTON3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 3, 1926 6. AGE (IN YEARS LAST BIRTHDAY) 61
IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☒ NEVER MARRIED ☐
Maryland USA WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD.10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
GLEN BURNIE NORTH ARUNDEL HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker 12b. KIND OF BUSINESS OR INDUSTRYUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE 12b. CITY OR TOWN 13a. INSIDE CITY LIMITS? YES ☒ NO ☐ 13b. STREET ADDRESS
Maryland Baltimore Md. 21230
120 E. Hamburg St. Balto.14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sigmond ----- Reckline Jenny ----- Berger16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
No (IF YES, GIVE WAR OR DATES) 218-22-3431 Mr. LeRoy C. Nauton, Sr. Same as above18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE
STREET
21g. DATE SIGNED
9/21/87

22a. I certify that (I) (the hospital) attended the deceased from 9/13, 1987, to 9/20, 1987, that (I) (we) last saw the deceased alive on 9/20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. PHYSICIAN'S NAME (TYPE OR PRINT) 22d. ADDRESS
ELLICOTT GORBATY, M.D. 7845 OAKWOOD ROAD, SUITE 205
GLEN BURNIE, MARYLAND 2106123a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9/24/1987 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Pk. 23d. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie, A.A.Co.Md.24. FUNERAL DIRECTOR NAME Balto. Md. 21230 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
McCully Funeral Home, 130 E. Fort Ave. SEP 22 1987 Julia Sander-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

BP

000001 173000

CLARA

ESTHER

WANDA

SEPTIMIA

WIDE WATERS COUNTY

NORTH WINDSOR HOSPITAL

WIDE WATERS

1000 BROADWAY, NEW YORK 100

NEW YORK, NEW YORK

WIDE WATERS COUNTY

065081 SEP-1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24916

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph H. Naylor, Jr.</i>			20. DATE OF DEATH MONTH DAY YEAR <i>09 02 87</i>			21. HOUR <i>9:16 A.M.</i>	
3. SEX <i>M</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 14 32</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>55</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY MD.</i>	
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL GENERAL HSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MECHANIC</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>ANNAPOLIS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH H. NAYLOR, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE BROWN</i>		16. STREET ADDRESS / ZIP CODE <i>Box # 300 Brownswood Rd. 21401</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-28-2260</i>		17. INFORMANT <i>Annapolis, Md. 21401</i> <i>ANNIE NAYLOR Box 300 Brownswood Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/2</i> 19 <i>87</i> to <i>7/2</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>7/2</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE		22c. DATE SIGNED <i>7/2/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9-5-1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HOPE CHURCH CEME.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Edgewater A.A. Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401</i>				25a. DATE REC'D BY REGISTRAR <i>SEP 8 - 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24917

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN DATE OF DEATH		MONTH		DAY		YEAR		21. HOUR					
GWENDOLYN I NORDBY								9-12		19		87		40		A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR		21. HOUR	
Female		White		1 - 29 - 09		78		MONTHS		DAYS		Pronounced Dead		9-12		19		87		8:44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STATE		14. CITY OR TOWN	
Rushton Mich.		USA		WIDOWED XX		DIVORCED		ANNE ARUNDEL MD		Annapolis		310 Melvin Ave.		Housewife		Household		FL		Brevard	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. MEDICAL CERTIFICATION		21. MEDICAL EXAMINER		22. DATE		23. TIME	
Herman Franklin Miller		Elsie Maude Burdick		No		385-05-2697		Elsie Sears 310 Melvin Ave, Annapolis Md.		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) A THRO SCLONOTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) TOBACCO ABUSE		MINUTES		MEDICAL CERTIFICATION		MEDICAL EXAMINER		DATE		TIME	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. MEDICAL CERTIFICATION		27. MEDICAL EXAMINER		28. DATE		29. TIME	
Cremation		9-14-87		Westview Park		Baltimore Md.		T.A. Hardesty Annapolis Md. 21401		SEP 15 1987		John Gordon Rader		MEDICAL CERTIFICATION		MEDICAL EXAMINER		DATE		TIME	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))

062812 SEP 18 81

SECTION 202



064942 SEP-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24918

1. DECEASED NAME (TYPE OR PRINT) Nicholas Norman			2a. DATE OF DEATH MONTH DAY YEAR 8 / Sept. 43 1987		2b. HOUR 18 p.m.
3. SEX Male	4. RACE Oriental/Brown	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indonesia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Millersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor Convalescent Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Harmans	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 200-09-3766		17. INFORMANT ADDRESS Ruden B. Norman, 146 Old Dorsey Rd., Harmans	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **metastatic lung cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OF PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 1667 Crofton Centre Dr.	21g. CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Sept 3 , 19 87 to Sept 3 , 19 87 that (I) (we) last saw the deceased alive on Sept 1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)			
22b. SIGNATURE P R HOOES MD		DEGREE MD	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P R HOOES MD		22e. ADDRESS 1667 Crofton Centre Dr.	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/8/87	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN Arlington, Va.
24. FUNERAL DIRECTOR NAME Kaufman Funeral Home		ADDRESS 5695 Main St., Elkridge	25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove contents of Pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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25% COTTON FIBRE

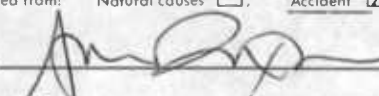
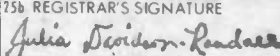
CHILLY M. DOWD

066847 SEP 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MDHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) TIMOTHY D. O'CONNELL									
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 26, 1966		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		7a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 22 1987	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		7d. HOUR 10:05 A.M.	
10. CITY OR TOWN OF DEATH DORSEY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 170 & 176				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EQUIPMENT OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY ALLIED CONST.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2114 CHANTILLA ROAD 21228	
14. FATHER'S NAME FIRST MIDDLE LAST STEVE O'CONNELL III				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET ROWAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-70-0088		17. INFORMANT ADDRESS STEVE O'CONNELL III SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 Multiple injuries IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:38 PM 9-22-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by train.			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 170 & 176 Anne Arundel, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER				DATE SIGNED 9-22-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/25/87		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		25a. DATE REC'D. BY REGISTRAR SEP 24 1987	
24. FUNERAL DIRECTOR LEORY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228				25b. REGISTRAR'S SIGNATURE 					

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1 SEP 24 1987

067114 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24920

1. DECEASED NAME (TYPE C) ANNIE E. OFFER			2a. DATE OF DEATH MONTH DAY YEAR 9/27/87		2b. HOUR 4:39 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 28 1919	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1900 D. Copeland Street 21401
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-7801	17. INFORMANT Balto., Md. 21207 MARCELLUS OFFER 19 Walden Holly Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cellulitis of legs DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 24 Sept 1987 , to 27 Sept 1987 , that (I) (we) lost saw the deceased alive on 27 Sept 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>John J. Jones MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 29 Sept 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-30-1987	23c. NAME OF CEMETERY OR CREMATORY PINDLAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

UNITED STATES DEPARTMENT OF JUSTICE

U.S.A.

WASHINGTON

AND ATTORNEY GENERAL

WASHINGTON

1987, 11-11-87

1987, 11-11-87

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064926 SEP-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 24921

1. DECEASED NAME (TYPE OR PRINT) SoTirios M. Panos			2a. DATE OF DEATH MONTH 9 DAY 1 YEAR 87		2b. HOUR 7⁰⁰ M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 18 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundee MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cecilia Arundel General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Restauranteur
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 155 Dewey Dr. 21401
14. FATHER'S NAME FIRST Michael S. MIDDLE Panagiotareas LAST Stamatiki			15. MOTHER'S MAIDEN NAME FIRST Apostolakis MIDDLE Apostolakis LAST Apostolakis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes (IF YES, GIVE WAR DATES) WWII		16b. SOCIAL SECURITY NO. 219-32-0196		17. INFORMANT Viola S. Panos ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 2° ventricular fib.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO, OR AS A CONSEQUENCE OF (b) Probable myocardial Infarction					Immediate
DUE TO, OR AS A CONSEQUENCE OF (c) Severe coronary artery disease					Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a 1) Generalized atherosclerosis 2) Emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6 , 19 87 , to 9/1 , 19 87 , that (I) (we) last saw the deceased alive on 8/24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph N. Friend M.D.		DEGREE		22c. DATE SIGNED 9/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend		22e. ADDRESS 205 Ridgely Ave. Annapolis, Md. 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 3, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Demetrius	
23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD		24. FUNERAL DIRECTOR NAME Laylor Funeral Chapel, Annapolis, MD ADDRESS			
25a. DATE REC'D. BY REGISTRAR SEP 04 1987		25b. REGISTRAR'S SIGNATURE J. L. Borden			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The following information was obtained from the records of the
 Department of the Interior, Bureau of Land Management, on September 30, 1964:
 The total area of the National Forest System lands in the State of
 California is 33,000,000 acres.

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 Department of the Interior, Bureau of Land Management, on September 30, 1964:
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 The total area of the National Forest System lands in the State of
 California is 33,000,000 acres.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24922

065547 SEP 15 1987

DECEASED NAME (PRINT) ALVIN S. PARKS		2a. DATE OF DEATH MONTH DAY YEAR Sept. 6 1987		2b. HOUR 3:50 P.M.	
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR SEP. 30 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AME Arundel Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor		12b. KIND OF BUSINESS OR INDUSTRY Restr./Store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5831 Rockhold Creek Rd/20751	
14. FATHER'S NAME FIRST MIDDLE LAST William S. Parks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella C. Ward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Louis Parks (same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) GI BLEEDING AND ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC PROSTATE CANCER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/6 19 87 , to 9/6 19 87 , that (I) (we) last saw the deceased alive on 9/6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles A. Seager		DEGREE M.D.		22c. DATE SIGNED 9/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. SEAGER M.D.		22e. ADDRESS 780 RITZLEIGH HWY SU PR.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-8-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD					
24. FUNERAL DIRECTOR NAME ADDRESS Randolph F. H. Owing M.D.		25a. DATE REC'D. BY REGISTRAR SEP 14 1987			
25b. REGISTRAR'S SIGNATURE John D. ...					

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows origin, injury, or other traumatic event, the medical examiner must be notified at once.

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ALTON FIBER

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SEP 14 1991

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24923 DT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT Varney PARKS		2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11, 1987		2b. HOUR 555 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1920	
6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Dame College		12c. ADDRESS 21061	
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Parks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Fisher		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII	
17. INFORMANT (Wife) Norma M. Parks		18. SOCIAL SECURITY NO. 217.05.6809		19. ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) shock lung DUE TO, OR AS A CONSEQUENCE OF (c) acute myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (R) pneumonectomy for lung cancer					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 1205 YORK ROAD, SUITE 38, LUTHERVILLE, MARYLAND 21093	
22. I certify that (I) (this hospital) attended the deceased from Sept 11, 1987 to Sept 14, 1987 , that (I) (we) last saw the deceased alive on Sept 11, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22a. SIGNATURE Frank A. Faraino, M.D.		22b. ADDRESS 1205 YORK ROAD, SUITE 38, LUTHERVILLE, MARYLAND 21093		22c. DATE SIGNED 9/11/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		24b. ADDRESS Glen Burnie, Maryland		24c. DATE REC'D. BY REGISTRAR SEP 15 1987	
25a. REGISTRAR'S SIGNATURE via Frederick		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file a report to the State Dept. of Health and Mental Hygiene.

002055 SEP 18 83

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067750 OCT-78

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24924

1. DECEASED NAME FIRST MIDDLE LAST RUSSELL Harrison PEARCE			2a. DATE OF DEATH MONTH DAY YEAR 8 7 9-28-1987		2b. HOUR 2:14 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 8, 1924	6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Office Supply Co	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Severna Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 44 Whittier Parkway 21146	
14. FATHER'S NAME FIRST MIDDLE LAST Russell H.W. Pearce			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Eney		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-18-5264	17. INFORMANT ADDRESS Alice Ruth Pearce 44 Whittier Pkwy. 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERCHOLESTEROLEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 5 , 19 85 , to 85 , that (1) (we) last saw the deceased alive on 5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.					
22b. SIGNATURE Charles A. Seager			DEGREE M.D.		22c. DATE SIGNED 9/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. SEAGER			22e. ADDRESS 780 RITCHIE HWY, SEVERNA PARK		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-31-1987	23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. MD	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO			25a. DATE REC'D. BY REGISTRAR 9/30/87		
ADDRESS SEVERNA PARK, MD. 21146			25b. REGISTRAR'S SIGNATURE Wardson-Randall		

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84
(VRA 15, 4)

Jim

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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067720 OCT-78

ROBERT S BARRANCO
SEVERN PARK MD. 21146

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 7 REG. NO. 2 4 9 2 5	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
KENNETH Harmon PIZER				SEPTEMBER 15, 1987 645 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1916	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
12a. USUAL OCCUPATION (RET.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President		12b. KIND OF BUSINESS OR INDUSTRY Pridemark, Ent			
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST Plummer Pizer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Diem		13d. INSIDE CITY LIMITS? YES NO X 13e. STREET ADDRESS 20 Harvard Road 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. NA		17. INFORMANT (Wife) E. Mae Pizer Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure		DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-25, 1987, to 9-15, 1987, that (I) (we) lost saw the deceased alive on 9-15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
SACIT EREN, M.D.		ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN		9-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 518 S. CAMP MEADE ROAD LINTHICUM, MARYLAND 21090			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE		Glen Burnie A A Co. Md.			
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME		ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 17 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

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SECRET

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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CONFIDENTIAL

SECRET

CONFIDENTIAL

066376 SEP 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24926

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL PLUMMER			2a. DATE OF DEATH MONTH DAY YEAR 09 16 87		2b. HOUR 5 A.M.
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 11 11 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH CROWNSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROWNSVILLE STATE HOSP. (COTTAGE 12)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD.			13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WALTER HANDERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT KNOWN. 21218		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN			16b. SOCIAL SECURITY NO. 212-78-5084		17. INFORMANT ADDRESS RECORDS.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8588 IMMEDIATE CAUSE (a) RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) ELEPHANTIASIS DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SYNDROME					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS. MANY YEARS 50 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I TOXIC DILANTIN + PHENOBARB LEVEL, EPILEPSY.					
19a. DATE OF OPERATION N.A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N.A.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-20-1936 to 9-16-1987, that (I) (we) last saw the deceased alive on 9-16-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Raman Sood M.D.			DEGREE M.D.		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMAN SOOD			22e. ADDRESS C/O CROWNSVILLE STATE HOSP. CROWNSVILLE MD. 21032		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9-17-87		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR SEP 21 1987			
23f. REGISTRAR'S SIGNATURE Julia Tindon-Randall		23g. REGISTRAR'S SIGNATURE			

24. FUNERAL DIRECTOR

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

000370 SEP 25 01

064781 SEP 1 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24927

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Frederick A. Poore			9 1 87			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	4 28 17	70 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Washington DC	USA			Anne Arundel MD			Annapolis	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Anne Arundel General Hosp			Plumber			US. Govt.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.			AA			Edgewater		
13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			322 Fairmont Dr. 21037					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Frederick A. Poore, Sr.			Annie J. Myers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes WWII			578033127			Marvell A. Poore same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } b) <i>Recurrent pleural effusions, possibly malignant</i> 2 yrs DUE TO, OR AS A CONSEQUENCE OF: c) <i>Severe COPD</i> 18 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>atherosclerotic cardiovascular disease</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>3/14</i> 19 <i>85</i> , to <i>8/9/1</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/13</i> 19 <i>86</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) witness body after death.			22b. SIGNATURE <i>Paul Perez</i>			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/2/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Perez MD</i>			22e. ADDRESS <i>2568 A Riva Rd, Annapolis MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/4/87			23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA Md.			24. FUNERAL DIRECTOR Hardesty Funeral Home 12 Ridgely Ave., Annapolis, Md. 21401			25a. DATE REC'D BY REGISTRAR SEP 3 1987		
			25b. REGISTRAR'S SIGNATURE <i>Julia Parker-Randall</i>					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		REG. NO. 87-4-1-8	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH	
FIRST MILDRED R. MIDDLE POPHAM LAST		MONTH 9 DAY 21 YEAR 87	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	W	MONTH 7 DAY 25 YEAR 17	70 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
ILL.	U.S.A.		GLEN BURNIE MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	1406 ISTD RD.	TEACHER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD.	GLEN BURNIE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST HENRY MIDDLE SHIVER LAST	FIRST UNK. MIDDLE LAST	1406 ISTD RD. 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
UNK.	359-12-8605	BRYSON POPHAM - son 313 Martins Cove Rd. 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/26/87</u> to <u>9/21/87</u> that (I) (we) last saw the deceased alive on <u>6/26/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	22c. DATE SIGNED
<u>James Chaconas</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	9/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<u>James Chaconas</u>		<u>1521 Ritchie Hwy Arnold Md 21012</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Removal	9-21-87		
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR	
State Anatomy Board		SEP 30 1987 <u>John Anderson</u>	
ADDRESS			
Balto., Md.			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24929

1. DECEASED NAME (TYPE OR PRINT) STANLEY MATTHEW POTOCKI			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20 1987		2b. HOUR EDT 2:48 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Postal
13a. STATE Illinois		13b. COUNTY Cook	13c. CITY OR TOWN Chicago	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Maxmillian Potocki		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gibula			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 321-22-0638		17. INFORMANT Kenneth A. Potocki	
				ADDRESS Woodbine, Maryland 15460 Union Chapel Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anoxic Encephalopathy</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17/87</u> 19 <u>87</u> , to <u>9/20/87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <u>Paul Young-Hyman</u>		DEGREE MD		22c. DATE SIGNED 9/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL YOUNG-HYMAN, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MD 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-25-87	23c. NAME OF CEMETERY OR CREMATORY St. Adalberts Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chicago, Cook, Illinois
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, MD.		25a. DATE REC'D BY REGISTRAR SEP 21 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 930

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ROBERT EUGENE PRITCHARD					Sept. 26 19 87					M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
Male	White	MONTH DAY YEAR 5 28 21		LAST BIRTHDAY 66 YRS.	MONTHS DAYS HOURS MIN.				September 26 19 87 1624	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Anne Arundel Co. MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL			Welder (Ret)		Allied Chem.			
13a. STATE				13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland				Anne Arundel	PASADENA	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		828 Swift Road		21122
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Paul Pritchard				Laura						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) ADDRESS 417 Walton Ave.				
No				NA		Mrs. Diana M. Rothe Balto., Maryland 21225				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIAC ARREST										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. A.S.C.V.D.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>William P. Jones</i>				TITLE (SPECIFY) M.D. DEPUTY				MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.d.				DATE SIGNED 9/27/87						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial				Sept 30, 1987		Glen Haven Mem. Park		Glen Burnie A A Co. Maryland		
24. FUNERAL DIRECTOR NAME <i>R. A. Hopson</i>				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		
Singleton Funeral Home Glen Burnie, Maryland				SEP 29 1987						

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Wm. H. Bond

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 2493 EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK PETER RADAWICH			2. DATE OF DEATH SEPTEMBER 17, 1987 5:20 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 2 1906	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor	12b. KIND OF BUSINESS OR INDUSTRY Clothing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7806 Chesapeake Road 21122
14. FATHER'S NAME FIRST MIDDLE LAST Frank Radawich	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ursula Lazauskas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-0480	17. INFORMANT ADDRESS Victoria Radawich Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardio Respiratory arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>CHF - ASTHMA</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14/87</u> 19 <u>87</u> , to <u>9/17/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/16/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
22b. SIGNATURE <u>Jorge B. Ramirez</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND. 21061		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/19/87	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore == Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR SEP 22 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24932

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul N. Randlett			2a. DATE OF DEATH MONTH DAY YEAR 09 21 87		2b. HOUR 2030
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TITLE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Auto Service	
13a. STATE MD		13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5 Tyler Court 21403
14. FATHER'S NAME FIRST MIDDLE LAST Norman Randlett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Zahniser		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE YEAR OR DATES Yes WWII	
16b. SOCIAL SECURITY NO. 167-05-4838		17. INFORMANT Lillian A. Randlett		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) Leukemia Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1973 to 9/21/87, that (we) lost saw the deceased alive on 9/21/87, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry J. Watkins		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. WATKINS		22e. ADDRESS 51 Franklin St. Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SEE 15)	23b. DATE Sept. 25, 1987	23c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Munhall Allegheny PA	25a. DATE REC'D. BY REGISTRAR SEP 24 1987	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the matter of the ...
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
[Signature]

RECEIVED
SEP 22 1881

Very truly yours,
[Signature]

065530 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 2 4 9 3 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERTA D. RAWLINGS			2a. DATE OF DEATH MONTH DAY YEAR 9-8-87		2b. HOUR 6:20 AM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 5 15 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 112 Southvilla Ave. 21401						
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN HARRISON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTA PINDELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-64-2694		17. INFORMANT Annapolis, Md. 21401 WILLIAM RAWLINGS 112 Southvilla Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac arrest**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASHD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **end stage renal disease**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William Reese</i>		DEGREE PHYSICIAN		22c. DATE SIGNED 9/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM REESE		22e. ADDRESS ANNE ARUNDEL Co			

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 9-10-1987	23c. NAME OF CEMETERY OR CREMATORY LAKEMONT MEM. GARDENS	23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville A.A. Maryland
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) SEP 14 1987 <i>Julia Denton-Randall</i>	

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

082230 SEP 12 93

1/12/93 12:00 PM

TO: S. C. O. B.

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

TELEPHONE: [illegible]

TELETYPE: [illegible]

MAIL: [illegible]

NOTES: [illegible]

APPENDIX: [illegible]

ENCLOSURES: [illegible]

066393 SEP 22 87

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2a. DATE KNOWN OF DEATH		2b. HOUR	
9-12-1987		2:10 PM	
2c. DATE PRONOUNCED DEAD		2d. HOUR	
9-12-1987		2:10 PM	
7. BALTIMORE CITY OR COUNTY OF DEATH			
ANNE ARUNDEL Co. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
ANNAPOLIS MD.		ANNE ARUNDEL GENERAL HOSP.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ADVERTISING		SELF EMPLOY	
13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1008 ROEHAMPTON VAIL 23452	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
JOHN REDMOND		BEATRICE STASTNY	
16. SOCIAL SECURITY NO.		17. INFORMANT	
318-28-5982		CAROLYN CANOLES REDMOND SAME AS 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY			
DUE TO, OR AS A CONSEQUENCE OF			
(b) ATHRO SCLEROTIC CARDIO VASCULAR DISEASE			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
14 X TOBACCO ABUSE AND HYPERTENSION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		21f. LOCATION	
		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
TITLE (SPECIFY)			
DEPUTY MEDICAL EXAMINER			
ACTUAL SIGNATURE		DATE SIGNED	
CHARLES A. SEAGER		9/12/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
CHARLES A. SEAGER		780 RITCHIE HWY	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		9-15-87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
FOREST LAWN		NORFOLK	
23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
SEP 21 1987		John A. Seager	
24. FUNERAL DIRECTOR			
BEALL-EVANS FUNERAL HOME ANNAPOLIS, MD.			

01-84 BP
25M
DHMM - 17
(VR A15 ME (5))

088383 SEP 55 81

RECEIVED



SEP 2 1955

SEP 2 1955

067162 SEP 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24935
REG. NO.1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

Minnie Viola Rogers

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

September 25, 1987

M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

March 22, 1919

6. AGE (IN YEARS LAST BIRTHDAY)

68

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel Co.

MD

10. CITY OR TOWN OF DEATH

Linthicum Heights

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

911 Wanda Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

A A Co.

13c. CITY OR TOWN

Linthicum Hgts.

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

911 Wanda Road

21090

14. FATHER'S NAME

Julius

MIDDLE

G.

LAST

Tucker

15. MOTHER'S MAIDEN NAME

Catherine

MIDDLE

Elizabeth

LAST

Ferguson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

NA

16b. SOCIAL SECURITY NO.

215.24.4514

17. INFORMANT (Son)

Robert L. Rogers, Jr. Severna Park, Md. 21146

ADDRESS 211 Woodloch Lane

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BRONCHOGENIC CARCINOMA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 MOS.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this person) attended the deceased from 9-14-87 to 9-24-87, that (I) (we) last saw the deceased alive on 9-14-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.

22b. SIGNATURE

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

9-28-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. J. P. Nepomuceno, M.D.

22e. ADDRESS

7845 Oakwood Road

Glen Burnie, Maryland

21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept 29, 1987

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven Mem. Park

23d. LOCATION (CITY OR TOWN)

Glen Burnie

COUNTY

A A Co.

STATE

Maryland

24. FUNERAL DIRECTOR

NAME

R. H. Robinson

ADDRESS

Singleton Funeral Home Glen Burnie, Maryland

25a. DATE REC'D. BY REGISTRAR

SEP 29 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Rodgers

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

087182 SEP 30 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO. 4936

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rachel Rogers SAGLE			2a. DATE OF DEATH MONTH DAY YEAR September 24, 1987		2b. HOUR MIN. 4:15 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 90	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Crofton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Crofton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Rogers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah P. Phipps		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-26-9350		17. INFORMANT Virginia L. Owens	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Alzheimer's disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9 23 19 87 , to 19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (we) (did not) view the body after death.					
22b. SIGNATURE Dr. Paul S. Rhodes		DEGREE MD		22c. DATE SIGNED SEPT 25, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul S. Rhodes, M. D.		22e. ADDRESS Suite 1 1667 Crofton Center Crofton, MD 21114			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE SEPT 26, 1987	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery/Baltimore,		23d. LOCATION CITY OR TOWN COUNTY STATE Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR SEP 30 1987	25b. REGISTRAR'S SIGNATURE Julia D. Rhodes

BP _____

067370 OCT-1-87

NAME	POSITION	DATE	REMARKS
James	Supervisor	September 1, 1987	
Maryland	USA		was awarded custody
Crofton	Crofton Convalescent Center		Home address
Maryland	Anne Arundel County		1801 Kings Lane, Crofton, MD 21114
Robert			
NO			

1. Paul A. Barker, M.D.

1801 Kings Lane, Crofton, MD 21114

SEP 30 1987

10000 minutes to go

SEP 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

66104 SEP 18 87

REG. NO. 4931

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA SAKAL			2a. DATE OF DEATH MONTH DAY YEAR 9-11-87		2b. HOUR 7:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 28 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker	12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1044 Spa Rd. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Zigmund Pawski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelkadia Jacewicz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Douglas Sakal ADDRESS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/7 87 9/11 87	
22a. I certify that (1) (his hospital) attended the deceased from 9/7 87 to 9/11 87, that (1) (we) lost saw the deceased alive on 9/11 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (should) and not view the body after death.					
22b. SIGNATURE Ew Cole		DEGREE MD		22c. DATE SIGNED 9/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ew Cole		22e. ADDRESS 51 Franklin St. #420 Annapolis Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-1987	23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION CITY OR TOWN COUNTY STATE Greens N.Y.
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel			25a. DATE REC'D. BY REGISTRAR SEP 17 1987		
ADDRESS Annapolis, Md.			25b. REGISTRAR'S SIGNATURE		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00104 SEP 18 07

ON FILE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24438

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

RENAE

M.

SANOSKE

2b. DATE KNOWN OF DEATH
ESTIMATED

MONTH DAY YEAR
9-23-87

2b. HOUR
M
10:40

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Nov. 20, 1967

6. AGE (IN YEARS)

19 YRS

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7c. DATE PRONOUNCED DEAD

MONTH DAY YEAR
9-23-87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel County

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

North Arundel Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Cashier

12b. KIND OF BUSINESS

Warehouse Store

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Anne Arundel

13c. CITY OR TOWN

Pasadena

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

7968 East Shore Rd. 21122

14. FATHER'S NAME

Adolph

MIDDLE

M.

LAST

Sanoske

15. MOTHER'S MAIDEN NAME

Virginia

MIDDLE

M.

LAST

McLeod

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

218 06 8113

17. INFORMANT

Virginia M. Maltby (same as 13a-e)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

8150 IMMEDIATE CAUSE (a) Blunt trauma to head

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

8:53PM 9-23-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

driver of an auto/fixed object impact subj.

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

street

21f. LOCATION

Burns Crossing & Clark Station Rds. Anne Arundel

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Dennis F. Smyth

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED

9-24-87

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept. 26, '87 Glen Haven Mem. Park

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (CITY OR TOWN)

Glen Burnie

COUNTY

Anne Arundel MD

24. FUNERAL DIRECTOR NAME

McGilly Funeral Homes

ADDRESS

3204 Mountain Rd.

Pasadena, MD 21122

25a. DATE REC'D. BY REGISTRAR

SEP 29 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-13. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

067172 SEP 30 87

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666496 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24939

1. DECEASED NAME (TYPE OR PRINT) Lawrence R. Schlereth			2a. DATE OF DEATH MONTH DAY YEAR September 20, 1987		2b. HOUR 6:15PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 22 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD	
10. CITY OR TOWN OF DEATH Severn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8236 WB&A Road (Home)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Whiskey Dist.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8236 W B & A Road 21144	
14. FATHER'S NAME FIRST MIDDLE LAST John H. Schlereth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella R. Silby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT Cathy Holland Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF, <i>Coronary Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Artery Disease</i> (b) <i>Coronary Artery Disease</i> (c) <i>Coronary Artery Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Chronic Kidney Disease - Terminal</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/30</i> , 19 <i>81</i> , to <i>9/20</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9/16/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rafael H. Marin</i>		DEGREE MD		22c. DATE SIGNED 9/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael H. Marin, M.D.		22e. ADDRESS St. Agnes Medical Center 3455 Wilkens Ave., Balto., MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/24/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park		23d. LOCATION Baltimore Howard Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Highway Balto Md		25a. DATE REC'D. BY REGISTRAR SEP 22 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

SEP 23 1981 004300

SEP 23 1981 004300

067321 OCT 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24940

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Earl Warfield Seward			2a. DATE OF DEATH MONTH DAY YEAR 8 1 9 22 87		2b. HOUR a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 10 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Businessman		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. CITY OR TOWN Grasonville	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Seward's Folley Grasonville, Md. 21638
14. FATHER'S NAME FIRST MIDDLE LAST Warfield Seward			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nita Timms		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. W.W.II Navy 215-588-228		
17. INFORMANT Mrs. Barbara J. Seward			ADDRESS Grasonville, Md. 21638		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

FATAL ARTERY DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(b) A S H P

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr 20 min

5 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Malignant lymphoma

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-18 19 71, to 9-22 19 87, that (I) (we) lost saw the deceased alive on 9-1 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Stephen P. Carney</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.	22e. ADDRESS Dutchmans Lane, Easton Md. 21601		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-25-87	23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville, Md. Q.A. Md.
24. FUNERAL DIRECTOR NAME Tom Helfenbein		25a. DATE REC'D. BY REGISTRAR SEP 30 1987	
ADDRESS Rt. #1 Box 66B Chester, Md. 21613		25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>	

027321 OCT-18



NOTES

[Faint, mostly illegible text from a document, possibly a report or letter, with some handwritten notes and stamps visible.]

067519 OCT-28

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 8 7 2 4 9 4 1
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
September 19, 1987 1:20 AM3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
June 1, 1912 6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio 7b. CITIZEN OF WHAT COUNTRY? United states 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.

10. CITY OR TOWN OF DEATH Annapolis 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Center 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk 12b. KIND OF BUSINESS OR INDUSTRY Retail

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Annapolis 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE Apt. 307 Bellerive Dr./21401

14. FATHER'S NAME FIRST MIDDLE LAST Charles Puriton 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
Mr. A. Frederick Sharpe 13304 Saratoga Ave. Saratoga, Calif. 9507018. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4 Sept 1987, to 19 Sept 1987, that (I) (we) saw the deceased alive on 18 Sept 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 22c. DEGREE 22d. DATE SIGNED 21 Sept 1987

22e. PHYSICIAN'S NAME (TYPE OR PRINT) 22f. ADDRESS 77 West St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9-21-1987 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md.

24. FUNERAL DIRECTOR NAME ADDRESS ROBERT S. BARRANCO J.A.B. SEVERNA PARK, MD. 21146 25a. DATE REC'D. BY REGISTRAR 10/01/1987 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

082210 001-588

SEVERNA PARK, MD. 21146
ROBERT S. BARRANCO

5088 SEP -98

Item 5, Film G531 9-10-37 SB

FOR
STATE per Funeral Home
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24342

1. DECEASED NAME (TYPE OR PRINT) Joseph Aloysius Sierko			2. DATE OF DEATH MONTH DAY YEAR September 4, 1987			2b HOUR 2 A.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 3, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD	
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 406 Irene Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant (Ret)	
						12b KIND OF BUSINESS OR INDUSTRY Steel Co.	

13a STATE Maryland		13b COUNTY A A Co.		13c CITY OR TOWN Glen Burnie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 406 Irene Drive 21061	
14 FATHER'S NAME FIRST MIDDLE LAST Stanley Sierko				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Borowski					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT (Daughter) Christine Perry		ADDRESS 9024 Ocean Pines Berlin, Md. 21811			

18 CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	--------------------------------------------------	--	--------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
----------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------	--	--------------------------------------------------------------------------------	--	--	--

21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
----------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------	--	---------------------------------------------------	--

22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 1983 to Sept 4, 1987 that (I) (we) last saw the deceased alive on Aug 25, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22a. SIGNATURE <u>Joseph Taler, M.D.</u>		DEGREE		22b. DATE SIGNED <u>Sept 4, 1987</u>	
---------------------------------------------	--	--------	--	-----------------------------------------	--

22a. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH TALER		22b. ADDRESS 95 AWAHART Rd. Glen Burnie, Md. 21061	
-------------------------------------------------------	--	-------------------------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A A Co. Maryland	
24 FUNERAL DIRECTOR NAME <u>D. H. H. H.</u> Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 8 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

2088 SEP-8 81



REBIA NOTIO 8003

AMC
WATF/HD

[Faint, mostly illegible text and markings covering the lower half of the page, possibly bleed-through from the reverse side.]

065281 SEP 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DATE OF DEATH 9 2 87 0230 M

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Manuel J. Silva3. SEX male 4. RACE Caucasian 5. DATE OF BIRTH MONTH DAY YEAR
May 12, 19207a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☒ NEVER MARRIED ☐
California United States WIDOWED ☐ DIVORCED ☐10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9. BALTIMORE CITY OR COUNTY OF DEATH
Gambrills 944 Fall Ridge Way Anne Arundel County, MD12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
Soldier U.S. Army13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13. STREET ADDRESS / ZIP CODE
Maryland Anne Arundel Gambrills YES ☒ NO ☐ 944 Fall Ridge Way / 2105414. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Manuel M. Silva Mary V. Brazil16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
Yes 1940-1974 549-22-8159 Evelyn J. Silva, Same as # 13.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Metastatic Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 1921c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a. I certify that (I) (this hospital) attended the deceased from July 27, 19 87, to Sept 2, 19 87, that (I) (we) last saw the deceased alive on Sept. 1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 22c. DATE SIGNED
Sandra W. Hairston MD 9/3/8722d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
Sandra W. Hairston, MD 3100 Wyman Park Dr., Baltimore, MD.23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
Burial Sept. 4, 1987 Arlington National Arlington Virginia24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
Beall Funeral Home 16000 Annapolis Rd. Bowie, Maryland 20715 SEP 09 1987 Julia Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other circumstances, the medical examiner must be notified or contacted.

062581 SEP 14 87

California	United States	xx	May 12, 1960	67
Gambella	Gen. John Ridge Way	Soldier	U.S. Army	
Maryland	Anne Arundel Gambella	X	Gen. John Ridge Way / 21054	
Manuel	M. Alice	Army	W. H. H. H.	
Yes	1940-1945 240-22-0122	Davidson, L. Allen, born as 13.		

X

2-7-7

X

Virginia Arlington Washington Maryland

SEP 9 1987

10000 Annapolis Md. County, Maryland 20710
 70011 Virginia Home
 10000 Annapolis Md. County, Maryland 20710

066488 SEP 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

249 44
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E. Simms			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 15 87		2b. HOUR M 0840
3. SEX M	4. RACE Neg	5. DATE OF BIRTH MONTH DAY YEAR 11 24 18	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH AA		MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 50 Clay Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE md					
13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 50 Clay Street					
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. SIMMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALLEN GOODRICH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W.11 160-9026		17. INFORMANT Annapolis, Md. 21401 MARYBELL SIMMS 92 Clay Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost. A.S.C.U.D. (b) A.S.C.U.D. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE William P. Jones		TITLE (SPECIFY) Deputy		DATE SIGNED 9/15/87	
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones		ADDRESS 695 America Ct. 21035			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-23-1987		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS CEME.	
23d. LOCATION CITY OR TOWN Crownsville A.A. Maryland		23e. DATE REC'D. BY REGISTRAR SEP 22 1987			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, PA		25. REGISTRAR'S SIGNATURE John Sander-Radach			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

Charles
M. H.
AA
AA

Charles
4.5.0.0.
Hyper

William P. Jones
Deputy
America Co. Street

05810 SEP 16 1987

FOR Item 18a thru 22a Film G631 9/28/87
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24945

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
Charlotte						Singer		8 7		9		5		1987		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Female		White		12 - 30 - 49		37 YRS.		MONTHS		DAYS		HOURS		MIN.		9		5		1987		12:05 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				USA								Anne Arundel County MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Ft. Meade				Kimbrough Army Hospital								Supply Officer				Hospital							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.				Anne Arundel		Gambrills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		871 Claffy Drive 21054													
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST						FIRST MIDDLE LAST																	
Henry Joseph Kaniecki, Sr.						Laverna						Gary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				212580946				Laverna Myrick				same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amitriptyline intoxication</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-5- 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Ingestion of drugs															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 871 Claffy Avenue Gambrills, Maryland															
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 9/6/87											
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS 111 Penn St.				Balto.MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				9/9/87				Loudon Park				Baltimore Balto. Md.											
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Hardesty Funeral Home, Annapolis, Md.								SEP 15 1987				<u>Julia Davidson-Randall</u>											

DIVISION OF VITAL RECORDS, 201 W. PREMON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PREMON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP 269
DHMH - 17
(VR A15 ME (15))

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MALEFIC

200% COTTON FIBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

8 7 REG. NO. 2 4 9 4 6

2a. DECEASED NAME (TYPE OR PRINT) Paul Vincent Smiley			2b. DATE OF DEATH MONTH DAY YEAR 9 25 87		2c. HOUR MIN. 3:30 P
3. SEX m	4. RACE C White	5. DATE OF BIRTH MONTH DAY YEAR 12 07 21		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) route mgr.		12b. KIND OF BUSINESS OR INDUSTRY Vending
13a. STATE MD			13b. COUNTY Calvert	13c. CITY OR TOWN Ches. Bch.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Baxter Smiley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aliza Coxe 20732		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 246121228		17. INFORMANT ADDRESS Burnette A. Smiley (same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) cigarette use DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 19 85 to Sept 25 19 87 , that (I) (we) lost saw the deceased alive on Sept 25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Stuart E. Selonick, M.D.			DEGREE MD		22c. DATE SIGNED 9/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.			22e. ADDRESS 51 Franklin St. Annapolis, Md. 21014		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-28-87		23c. NAME OF CEMETERY OR CREMATORY Southern Mem Gardens	
24. FUNERAL DIRECTOR NAME Rausch FH Owings		ADDRESS MD 20736		25a. DATE REC'D. BY REGISTRAR OCT 01 1987	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

BP

100-120 184700

20% COTTON FIBER

100-120

100-120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

AKA *Angy A. Riley Smith*
1. Annie A. Riley Smith

2a. DATE OF DEATH MONTH DAY YEAR
Sept 27 1987 7 P.M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Mar. 1, 1895

6. AGE (IN YEARS LAST BIRTHDAY)

92

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 72 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

200 Howison Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

AA

13c. CITY OR TOWN

Annapolis

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

200 Howison Road 21401

14. FATHER'S NAME

George W. Riley

15. MOTHER'S MAIDEN NAME

Jennie Florence Goodwin

16a. WAS DECEASED BY IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

214-36-2169

17. INFORMANT

Eva Jackson-

ADDRESS

Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary edema

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic atrial fibrillation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) Chronic atherosclerotic heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Anemia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *2/27* 19 *80* to *9/27* 19 *87* and that in (my) (our) opinion death occurred on the date and hour and from the causes statedsaw the deceased alive on *9/25* 19 *87*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

My Samaras

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

9/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

George C. Samaras

22e. ADDRESS

205 Ridgely Ave Annapolis, MD

23a. BURIAL, CREMATION, REMOVAL (CITY)

Burial

23b. DATE

Sept 29, 1987

23c. NAME OF CEMETERY OR CREMATORY

Cedar Bluff

23d. LOCATION

CITY OR TOWN

Annapolis AA MD

21401

24. FUNERAL DIRECTOR

Taylor Funeral Chapel - Annapolis, MD

25a. DATE REC'D. BY REGISTRAR

OCT 1 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
It also mentions the
main problems of the
country and the
state of the economy.
The second part of the
report describes the
main problems of the
country and the
state of the economy.

The third part of the
report describes the
main problems of the
country and the
state of the economy.
The fourth part of the
report describes the
main problems of the
country and the
state of the economy.
The fifth part of the
report describes the
main problems of the
country and the
state of the economy.
The sixth part of the
report describes the
main problems of the
country and the
state of the economy.
The seventh part of the
report describes the
main problems of the
country and the
state of the economy.
The eighth part of the
report describes the
main problems of the
country and the
state of the economy.
The ninth part of the
report describes the
main problems of the
country and the
state of the economy.
The tenth part of the
report describes the
main problems of the
country and the
state of the economy.

068299 OCT 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 REG. 4948

1- STATE REGISTRAR		2- DATE OF DEATH		3- MONTH		4- DAY		5- YEAR		6- HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		DATE KNOWN OF DEATH		ESTIMATED	
Jami Leigh Smith								9/ 30/ 87		10:12 P M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS.	9 DATE PRONOUNCED DEAD		10 MONTH		11 DAY	
Female	W	10 19 77	9 YRS.			9/ 30/ 19 87					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 MONTH		11 DAY	
Maryland		USA				Anne Arundel County, MD					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		13a STATE		13b COUNTY	
Annapolis		Anne Arundel General Hospital		Student				Maryland		Anne Arundel	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		13f ZIP CODE	
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1003 Sherwood Forest Rd.		21401	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO.		17 INFORMANT		18 ADDRESS	
Gerry L. Smith		Gloria Dean Newton		No				Gerry L. Smith #13			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		21a EXTERNAL CAUSE WAS		21b TIME OF INJURY		21c HOW INJURY OCCURRED	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		9:30 P.M. 9/ 30/ 1987		subject passenger of auto/auto collision	
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION		21g CITY OR TOWN		21h COUNTY		21i STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		roadway		Generals Hwy. & Knollwood Dr.,		Annapolis,		Anne Arundel Co., Md.			
22a I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		22b death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22c TITLE (SPECIFY)		22d DATE SIGNED	
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		Assistant MEDICAL EXAMINER		10/1/87					
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY		23f STATE	
Burial		10/4/87		Lakemont Cemetery		Davidsonville AA		Md.			
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c DATE REC'D. BY REGISTRAR		25d REGISTRAR'S SIGNATURE			
Hardesty Funeral Home, Annapolis, Md.		OCT 09 1987		John Davidson-Randall							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
TERESA		MYRTLE		SNOWDEN				09 10 87		9:10 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		B		JAN 26 1909		78		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MD		U.S.A.				Anne Arundel				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Edgewater		Pleasant Living Conv. Center		Nurse							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Md		A.A.		Edgewater				21237		21437	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Albert		SNOWDEN		ELIZABETH		BROWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO		381-22-5878		MALISSA H. STEPHEN		1574 CROWNSVILLE RD					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
John B. Lowe		MD						9-10-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
John B. Lowe		MD		77 West ST ANNAPOLIS, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9-15-87		ST Marys Catholic		ANNAPOLIS A.A. Md					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
C.E. Hicks		1922 Forest Drive		SEP 17 1987		A. J. Anderson-Randall					

BP _____

000137 SEP 1961

Township of ...

B
Jan 24 1962

Edgewater ...

W.D. ...

Street ...

NO ...



...
...
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067414 OCT -2187

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		REG. NO. 2435	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeannette B. Sowden		2a. DATE OF DEATH MONTH DAY YEAR 9-28-87 2b. HOUR 2:00 P.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 2 12 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		10. CITY OR TOWN OF DEATH Pasadena	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 255 Meadow Road Pasadena Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Md.	
13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 255 Meadow Road 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Blittersdorf		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McHugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 194 18 8680	
17. INFORMANT ADDRESS Charles W. Sowden (same as 13E)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS (METASTATIC)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PRIMARY SPONGIOUS CARCINOMA LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 MONTHS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>JUNE</u> 19 <u>87</u> to <u>SEPT 28</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MAY 2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (they) did not view the body after death.			
22b. SIGNATURE Arthur Lankford, Jr. M.D.		22c. DATE SIGNED 9-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR LANKFORD, JR. M.D.		22e. ADDRESS 2934 MOUNTAIN RD PASADENA, MD. 21122	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 2/29/87	
23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME George Gonce		25a. DATE REC'D. BY REGISTRAR OCT - 1 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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9-25-58

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TO: DIRECTOR, FBI (100-371000)
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[Illegible text follows, including a large 'X' mark and various lines of text that are mostly illegible due to fading and bleed-through.]

066695 SEP 24 87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 24251
20. DATE OF DEATH MONTH DAY YEAR 2b HOUR
September 6, 1987 1 MDECEASED NAME FIRST MIDDLE LAST
Martha E. Spedden

3. SEX Female 4. RACE Caucasion 5. DATE OF BIRTH MONTH DAY YEAR July 8, 1901 6. AGE (IN YEARS LAST BIRTHDAY) 86 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) virginia 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD

10. CITY OR TOWN OF DEATH Millersville 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor N.H. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Millersville 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE 889 Cecil Ave. MD 21108

14. FATHER'S NAME FIRST MIDDLE LAST John Clark 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina E.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Betty Spedden 1599 Crofton Pkwy. 21114

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Alzheimer's disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/20, 19 82, to 9-6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Paul S. Rhodes MD 22c. DATE SIGNED 9 8 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul S. Rhodes MD 22e. ADDRESS 1667 Crofton Center Crofton

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9-9-1987 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balt MD

24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OPTION CHECK



ROBERT S. BARRANCO

067459 OCT-28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRS 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) DAISY SPRIGGS					2a. DATE OF DEATH MONTH 9 DAY 29 YEAR 87					2b. HOUR M
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 9 DAY 1 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1624 Clay Hill Road		
14. FATHER'S NAME FIRST EDWARD MIDDLE LAST SPRIGGS					15. MOTHER'S MAIDEN NAME FIRST ISABELLE MIDDLE LAST HAMMOND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Annapolis, MD: 21401 GLADYS S. COOK 1624 Clay Hill Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 9/12 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mins
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/1 19 87 to 9/29 19 87 , that (I) (we) lost ^{now} the deceased alive on 9/28 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. KARIPIDENI					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. KARIPIDENI MD					22e. ADDRESS 200 HOSPITAL DR #300 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-2-1987		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CHURCH CEME.		23d. LOCATION CITY OR TOWN Arnold A.A. COUNTY Maryland STATE 				
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.					25a. DATE REC'D. BY REGISTRAR OCT 01 1987					
					25b. REGISTRAR'S SIGNATURE Julia Simon-Pedro					

BP

0678780 123-56

100 01 084

065084 SEP -9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

EDT

87 REG. NO. 24953
7a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR AM
SEPTEMBER 05, 1987 959 M1. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) LEON LYDEN STACK3. SEX
Male4. RACE
White5. DATE OF BIRTH MONTH DAY YEAR
Jan. 31, 19146. AGE (IN YEARS LAST BIRTHDAY) YRS.
737c. IF UNDER 1 YEAR MONTHS DAYS 7d. IF UNDER 24 HRS. HOURS MIN.
M7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD.10. CITY OR TOWN OF DEATH
GLEN BURNIE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NORTH ARUNDEL HOSPITAL)12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant12b. KIND OF BUSINESS OR INDUSTRY
US Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland13b. COUNTY
A A Co.13c. CITY OR TOWN
Linthicum Heights13d. INSIDE CITY LIMITS? YES ☐ NO ☒13e. STREET ADDRESS
226 Homewood Road 2109014. FATHER'S NAME FIRST MIDDLE LAST
Leon Lyden Stack, Sr.15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ida W. Hardtke16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No16b. SOCIAL SECURITY NO.
705.07.238317. INFORMANT (Wife)
Anne E. StackADDRESS
Same as #1318. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) syncope - Sudden Death - Acute cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Emphysema
(c) pneumectomy - R LUNG CANCERDUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OFAPPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
5 year
10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐ YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/05 19 87 to 9/05 19 87 that (I) (we) last saw the deceased alive on 9/05 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ELLIOTT GORBATY, M.D.

22e. ADDRESS

ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN

7845 OAKWOOD ROAD, SUITE 203
GLEN BURNIE, MARYLAND 2106123a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial23b. DATE
Sept 9, 198723c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park

23d. LOCATION CITY OR TOWN

Elkridge

COUNTY

Howard Co. Md.

24. FUNERAL DIRECTOR NAME

R. H. Hopkins
Singleton Funeral Home Glen Burnie, Maryland

25a. DATE REC'D. BY REGISTRAR

SEP 8 1987

25b. REGISTRAR'S SIGNATURE

R. H. Hopkins

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

1000

067193 SEP 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 24954 EDT
REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST ROBERT REYNOLDS STAEHLIN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24, 1987		2b. HOUR MIN 1028 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 19 1931		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 56		8. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sr. Engineer		12b. KIND OF BUSINESS OR INDUSTRY A.I. Corp.	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1714 Manning Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Staehlin Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Reynolds		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213-30-8955		17. INFORMANT ADDRESS Isabelle Staehlin Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock - unknown DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/24 19 87 , to 9/24 19 87 , that (I) (we) last saw the deceased alive on 9/24/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gerald Blum					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD CHURCH, M.D.					22e. ADDRESS 8 EVERGREEN ROAD AT RIGGS AVENUE SEVERNA PARK, MARYLAND 21146				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/28/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore A.A. Md			
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md						25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return page 1 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001103 SEP 30 05

MAILED
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NOV 1905

065824 SEP 68

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 2 4 9 5 EDT
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRY STANLEY STANDIFORD SR			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11 1987		2b. HOUR 305 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 8, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Board of Education
13a. STATE Maryland			13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin F. Standiford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Sanders		13e. STREET ADDRESS / ZIP CODE 334 Gatewater Court Apt 204 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Wife) ADDRESS Louise A. Standiford Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) _____ the body after death.

22a. SIGNATURE <i>Jose M. Presbitero</i>	DEGREE M.D.	22b. DATE SIGNED 9/11/87
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M.D.		22d. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 14, 1987	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland
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24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Glen Burnie, Maryland	25a. DATE REC'D. BY REGISTRAR SEP 15 1987	25b. REGISTRAR'S SIGNATURE <i>L. A. Davidson-Randall</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

065300 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 REG 4 9 5 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Alberta</i>		MIDDLE		LAST <i>Stevens</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 4 1987		2b. HOUR M	
3. SEX <i>F</i>	4. RACE <i>Cau</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6 25 25</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>62 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 9 4 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>AA</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Grande</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Packer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Aerosol Cans</i>			
13a. STATE <i>Md</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>APT A 21061 Furnace Br Rd</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>===== Shafchak</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>=====</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>209-16-2083</i>		17. INFORMANT <i>Glen Burnie Md 21061</i> <i>Frank E. Stevens Jr. 7622 Marcy Drive</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>A.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Hypertension</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William P. Jones, MD</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER				DATE SIGNED <i>9/4/87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>William P. Jones, MD</i>		ADDRESS <i>695 America Ct. 21035</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/8/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore A.A. Md</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>George J. Gonce 4001 Ritchie Hgwy Balto Md</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 09 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Gordon-Rose</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

082300 SEP 14 07



SEP 08 1907

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24951

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Alice

Elizabeth

Stevens

20. DATE OF DEATH

MONTH

DAY

YEAR

20. HOUR

9-27-87 11:30 AM

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH

DAY

YEAR

12 - 20 - 07

6. AGE (IN YEARS LAST BIRTHDAY)

79

YRS.

UNDER 1 YEAR

MONTHS

DAYS

UNDER 24 HRS.

HOURS

MIN.

70. BIRTHPLACE

STATE OR FOREIGN

Maryland

70. CITIZEN OF WHAT COUNTRY?

United States

8

MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

ANNE ARUNDEL G

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

ANNE ARUNDEL General Hosp

120. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Owner/Operator

120. KIND OF BUSINESS OR

INDUSTRY

Hardware

130. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

130a. STATE

Florida

130b. COUNTY

West Palm Beach

130c. CITY OR TOWN

West Palm Beach

130d. INSIDE CITY LIMITS?

NO ☐

130e. STREET ADDRESS

2911 Ashley Drive West/33415

14. FATHER'S NAME

William

MIDDLE

F.

LAST

Lins

15. MOTHER'S MAIDEN NAME

Annie

MIDDLE

LAST

Summers

160. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

160. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

215-22-8136D

17. INFORMANT

Laura Duncan

ADDRESS

311 South Lake Drive

Stevensville, MD 21666

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCVD

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

190. DATE OF OPERATION

190. CONDITION FOR WHICH OPERATION WAS PERFORMED

200. AUTOPSY?

YES ☐ NO ☐

200. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

210. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

210. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

210. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

210. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

210. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

210. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

220. I certify that (I) (this hospital) attended the deceased from Sept 16, 19 87, to Sept 27, 19 87, that (I) (we) last

saw the deceased alive on Sept 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

220. SIGNATURE

B. Furlow

DEGREE

MD

ATTENDING

PHYSICIAN ☒

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

220. DATE SIGNED

9/28/87

220. PHYSICIAN'S NAME (TYPE OR PRINT)

B. Furlow

220. ADDRESS

77 West St Annapolis

230. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

230. DATE

10-1-87

230. NAME OF CEMETERY OR CREMATORY

Asbury U.M.C. Cemetery

230. LOCATION

CITY OR TOWN

Arnold, A.A.,

COUNTY

MD

STATE

24. FUNERAL DIRECTOR

BARRANCO

ROBERT S. BARRANCO

SEVERNA PARK, MD. 21146

250. DATE REC'D. BY REGISTRAR

OCT 05 1987

250. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a post-mortem examination required.

101331 100-808



RECEIVED
FBI
OCT 10 1964

065131 SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 24958 EDT

1. DECEASED NAME (TYPE OR PRINT) LEANNA A STONEBRAKER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 4, 1987		2b. HOUR 1040 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7/9/1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William E. Cain, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Waugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-07-9548		17. INFORMANT ADDRESS Carroll A. Stonebraker Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Ovarian Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d 2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> , 19 <u>87</u> , to <u>9-4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Long S. Hsu</u>		DEGREE MD.		22c. DATE SIGNED 9-5-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.		22e. ADDRESS 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., A.A. Co., Md.
24. FUNERAL DIRECTOR NAME McCully Funeral			237 E. Patapsco Ave., Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR SEP 09 1987
			25b. REGISTRAR'S SIGNATURE <u>John Davidson Riddle</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062131 SEP 10 87

GEN BARNETT
NORTH AVENUE HOSPITAL

SEP 09 1987

067371 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 24959

FOR 1- STATE REGISTRAR		1- DECEASED NAME (TYPE OR PRINT)		FIRST Martha	MIDDLE Glotfelty	LAST Tallerico	2a. DATE OF DEATH MONTH DAY YEAR September 21, 1987		2b. HOUR 11:00p		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH Davidsonville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 864 Bridle Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Retail Lumber					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Davidsonville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 864 Bridle Way / 21035			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence C. Glotfelty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Swager		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 176-14-0168		17. INFORMANT 117 5th Street S.E. Linda Tallerico Loftus, Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer of the Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11-87</u> , 19 <u>87</u> , to <u>8-22-87</u> , that (I) (we) lost saw the deceased alive on <u>8-25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert Greenfield</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Sept. 22, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Greenfield, M.D.		22e. ADDRESS 139 Old Solomons Island Rd. Annapolis, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR SEP 30 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Rodwell</u>					

BP

065440 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ALEKSANDRA TARNOWSKI			2a DATE OF DEATH MONTH DAY YEAR September 7, 1987			2b HOUR M AM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12/9/1893		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD				
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 Twelfth Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaker		
13a STATE Maryland			13b COUNTY A.A.		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 209 Twelfth Ave., 21225	
14 FATHER'S NAME FIRST MIDDLE LAST Hipolet Karwowski			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jozefa Czwalina			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16b SOCIAL SECURITY NO. 215-07-7053			17 INFORMANT 205 12th Ave., Balto. Md. 21225 B Catherine L. Benicewicz			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: IMMEDIATE										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 8/28/87 to 9/9/87 that (I) (we) last saw the deceased at home and that in my (our) opinion death occurred on the date and hour and from the causes stated above.										
22b SIGNATURE Dr. Oleg D. Zimmerman, M.D.				DEGREE MD		22c DATE SIGNED 9/9/87		22d ADDRESS 200 Hospital Drive, Suite 300 Glen Burnie, Maryland 21061		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/10/87		23c NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Balto., A.A. Co., Md.				
24 FUNERAL DIRECTOR NAME McCully Funeral Homes				24b ADDRESS 237 E. Patapsco Ave., Balto., Md. 21225		25 DATE OF DEATH SEP 14 1987				
25a REGISTRAR'S SIGNATURE Julia Anderson-Rucker				25b REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury or other traumatic event, the medical examiner must be notified at once.

062440 SEP 12 85

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "TO", "FROM", and "SUBJECT" are faintly visible.]

067420 OCT-20

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24961

1. DECEASED NAME (TYPE OR PRINT) Charles C. Taylor Jr.			2a. DATE OF DEATH MONTH DAY YEAR 9-27-87		2b. HOUR MIN. 30
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 2-18-05		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Service
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 108 Defense Highway 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Taylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agusta Crandell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 268-12-5278		17. INFORMANT ADDRESS Charles C. Taylor, III - 165 Defense Highway Annapolis, MD 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URO-Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's disease, dementia.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan '87 19____ to Present 19____, that (we) last saw the deceased alive on 9/27/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.					
22b. SIGNATURE Peter F. VerKouwen		DEGREE MD		22c. DATE SIGNED 9/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN		22e. ADDRESS 1833 Forest Drive Annapolis, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 30, 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel, Annapolis, MD		ADDRESS OCT 1 1987		25a. DATE REC'D. BY REGISTRAR OCT 1 1987	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Rodgers	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

05-130 03 1520

67196 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 24962

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Flossie

S.

Thomas

2a. DATE OF DEATH

MONTH

DAY

YEAR

September 25 1987

2b. HOUR

7:30PM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

January 13 1906

6. AGE (IN YEARS (LAST BIRTHDAY))

81

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel

MD.

10. CITY OR TOWN OF DEATH

Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1601 Jennings Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Home Maker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

A.A.

13c. CITY OR TOWN

Glen Burnie

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1601 Jennings Road 21061

14. FATHER'S NAME

FIRST
Henley

MIDDLE

LAST

Williams

15. MOTHER'S MAIDEN NAME

FIRST
Matilda

MIDDLE

LAST

Hall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

229-12-5925

17. INFORMANT

ADDRESS

Larry A. McCormick 5205 Disney Ave Balto Md 21225

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastatic ca of Pancreas

DUE TO, OR AS A CONSEQUENCE OF

(c)

HSS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/15, 19 87, to 9/20, 19 87, that (I) (we) last saw the deceased alive on 9/20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Giorgio A. Raff

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

9/28/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

GIORGIO A. RAFF

22e. ADDRESS

1404 cran Hwy Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9/28/87

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven Memorial Pk

23d. LOCATION
CITY OR TOWN

Glen Burnie

COUNTY

A.A.

STATE

Md

24. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hwy Balto Md

25a. DATE REC'D. BY REGISTRAR

SEP 29 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8 1 0 0 2 0 0 1 0 0

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24763

FOR
1 - STATE
REGISTRAR

9-21-87 dw

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Grace Amelia Thomas

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

Sept 12 1987 2:30 A.M.

3. SEX

Female

4 RACE

B 2

5 DATE OF BIRTH

MONTH

DAY

YEAR

Dec 23 1902

6 AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

84

MONTHS

DAYS

HOURS

MINS

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

md

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

A.A.

MD

10 CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Annapolis Convalescent Center

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cook

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE

(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

md

13b COUNTY

A.A.

13c CITY OR TOWN

Annapolis

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

3262 Kitty Duval 21403

14 FATHER'S NAME

FIRST

MIDDLE

LAST

Charles

Larkins

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

CAROLINE

Pindell

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

216-24-0954

17. INFORMANT

JOAN D. Houghton

ADDRESS

3262 Kitty Duval

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH CAUSED BY:

IMMEDIATE CAUSE (a)

Acute vaginal Bleeding

DUE TO, OR AS A CONSEQUENCE OF

(b) Severe Urine Ca

DUE TO, OR AS A CONSEQUENCE OF

(c) Renal failure

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

4 days

?

years -

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

Severe Rheumatoid arthritis; Anemia of chronic disease; dementia

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) the hospital attended the deceased from 1974 to Present, that (1) the deceased (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

Dr Peter Ver Kouw MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

9/14/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr Peter Ver Kouw MD

22e ADDRESS

1833A Forest Drive

Annapolis md

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

Sep 16-1987

23c NAME OF CEMETERY OR CREMATORY

PineLawn Cemetery

23d LOCATION

CITY OR TOWN

COUNTY

STATE

Annapolis A.A. md

24 FUNERAL DIRECTOR

NAME

C.E. Hicks III

ADDRESS

1922 Forest Drive

CITY OR TOWN

Annapolis, md

COUNTY

A.A.

STATE

md

25a DATE REC'D BY REGISTRAR

SEP 17 1987

25b REGISTRAR'S SIGNATURE

in Division Randlee

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be processed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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067418100-2.87

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 24964

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Joseph Tyler			2a. DATE OF DEATH MONTH DAY YEAR Sept 28, 1987		2b. HOUR M M
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Boat Builder	
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14. STREET ADDRESS / ZIP CODE Arundel-on-the-Bay Road 21403	
14. FATHER'S NAME FIRST MIDDLE LAST George Tyler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Milton		16. ADDRESS 1950 Palm City Rd #1104 Stuart, FL 34994	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-16-9170		17. INFORMANT Marjorie Carfagno-Stuart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF (c) year 5					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 27 , 19 87 , to Sept 27 , 19 87 , that (I) (we) last saw the deceased alive on Sept 27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) told (did not) view the body after death.					
22b. SIGNATURE Dr. William C. Weintraub		22c. DEGREE MD		22d. DATE SIGNED 9/28/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM C. WEINTRAUB		22f. ADDRESS 2565 A. Riva Rd. Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct 1, 1987	23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR OCT 1 1987	25b. REGISTRAR'S SIGNATURE Julia Friedman-Randall

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1955-1956

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1955-1956

1955-1956

1955-1956

065297 SEP 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24965

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Azalea A. Utz			20. DATE OF DEATH MONTH DAY YEAR HOUR 09 07 87 238 M	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12 24 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1328 Harmony Lane 21401		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered nurse 12b. KIND OF BUSINESS OR INDUSTRY hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1328 Harmony Lane 21401
14. FATHER'S NAME FIRST MIDDLE LAST Frank Sturkie		15. MOTHER'S MAIDEN NAME MIDDLE LAST Lillie Hook		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 60 9400		17. INFORMANT ADDRESS Elmer W. Utz (same as 13E)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THE CAUSE CANCER OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/15/87, 1987, to 9/7/87, 1987, that (I) (we) last saw the deceased alive on 8/15/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Stanley P. Watkins		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley P. Watkins		22e. ADDRESS 51 Franklin Ave Annapolis Md 21404		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 9/10/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME George Gonce		4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR SEP 09 1987
25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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10% COTTON

SEP 08 1987

065823 SEP 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 24960

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Lilly VanHoose			2a. DATE OF DEATH MONTH DAY YEAR September 12, 1987		2b. HOUR 4:00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 22, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 313 Georgia Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland	13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 313 Georgia Avenue 21061	
14. DEATH'S NAME FIRST MIDDLE LAST Arthur Burke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Davidson		16. ADDRESS 1726 Linden Avenue Balto., Md. 21217	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Son) Larry VanHoose	18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>colorectal cancer metastatic to liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 3, 1987</u> to <u>September 12, 1987</u> , that (I) (we) last saw the deceased alive on <u>September 4, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Anna W. Berkman</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anna W. Berkman		22e. ADDRESS South Baltimore General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 15, 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park, A A Co., Md.		
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 15 1987	25b. REGISTRAR'S SIGNATURE <u>Anna Davidson-Randall</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that if a death certificate is to be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified.

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20% COTTON FIBER

WILKINSON



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OR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24767

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emery Lamartine Van Horn			2. DATE OF DEATH MONTH DAY YEAR 9 - 12 - 87			2b. HOUR 6:20aM	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 9 - 01 - 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD	
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 811 Cottonwood Drive / 21146				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineering	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 811 Cottonwood Drive / 21146		14. FATHER'S NAME FIRST MIDDLE LAST Leon E. Van Horn			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WW II		14b. SOCIAL SECURITY NO. 090-20-4660		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Battan			
15. INFORMANT Mrs. Pauline S. Van Horn (Same as # 13)		16. ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>—</u>							
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>87</u> to <u>9-12</u> 19 <u>87</u> and that (1) (we) last saw the deceased alive on <u>87</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the cause stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Arnold Alexander MD</u>				DEGREE MD		22c. DATE SIGNED 9-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD ALEXANDER, MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-87		23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville, A.A., MD	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO				24b. ADDRESS SEVERNA PARK, MD. 21146		25a. DATE REC'D. BY REGISTRAR SEP 17 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page covered 2 should be filed with 1972 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4 9 6 8

1. DECEASED NAME (TYPE OR PRINT) Charles Vykoukal			2a. DATE OF DEATH MONTH DAY YEAR 9 - 9 - 87		2b. HOUR 12:22a _M
3. SEX Male	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR 3 - 22 - 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Dupont Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Vykoukal			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Bakir		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-1893	17. INFORMANT ADDRESS Mrs. Margaret Vykoukal (Same as #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conclusive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> , 19 <u>87</u> , to <u>Sept. 2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Aug 22</u> , 19 <u>87</u> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Charles J. W. M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Sept. 10, 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. W. M.D.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 9-12-87	23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Howard, MD
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANGO		25a. DATE REC'D. BY REGISTRAR SEP 17 1987		25b. REGISTRAR'S SIGNATURE <u>John London-Paul</u>	
SEVERNA PARK, MD. 21146					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

000112 SEP 18 87

ROBERT B. GARRAND
SEVERN PARK MD 21146

067440 OCT-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 969

1- STATE REGISTRAR		2- REG. NO.	
3- SEX Male		4- RACE White	
5- DATE OF BIRTH 7-30-1924		6- AGE (IN YEARS) 63 YRS.	
7a. DATE KNOWN OF DEATH 9-29-87		7b. HOUR 10:25 M	
8- BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9- BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD	
10- CITY OR TOWN OF DEATH Severn		11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1058 Minnetonka Road	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Supervisor Ret.		12b. KIND OF BUSINESS OR INDUSTRY Amstar	
13a. STATE Md.		13b. COUNTY A.A. Co	
13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1058 Minnetonka Rd.		14. FATHER'S NAME Charles Wagner	
15. MOTHER'S MAIDEN NAME Mary Pusey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 212-20-6229		17. INFORMANT Morris Wagner	
17. ADDRESS Severn, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Lung carcinoma</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21b. TIME OF INJURY P.M. 9 29 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	
21f. LOCATION 1058 Minnetonka Rd, Severn, A.A. Co, MD.		22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Mario F. Golle, Jr.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.		DATE SIGNED 9/30/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-1-87	
23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION (CITY, TOWN, COUNTY, STATE) Balt. Balt. Md.	
24. FUNERAL DIRECTOR Name Hardsley Funeral Home		25a. DATE REC'D. BY REGISTRAR OCT 1 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07:84
25M

BP

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

087110 OCT-58

Mr. J. Edgar Hoover
Washington, D.C.

Department of Justice
1000 Maryland Ave.
Washington, D.C.

Mr. J. Edgar Hoover
Washington, D.C.
Dear Sir:



Very truly yours,
J. Edgar Hoover
Director

065078 SEP 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) EVA WALKER					2a. DATE OF DEATH MONTH 9 DAY 2 YEAR 1987		2b. HOUR M			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 8 DAY 14 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		
7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 215 B Farragut Court Apt. 205				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST TILMON MIDDLE STITH LAST MACLIN					15. MOTHER'S MAIDEN NAME FIRST DINAH MIDDLE MACLIN LAST MACLIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 231-22-1551		17. INFORMANT ADDRESS Annapolis, Md. 21403 FRANCES WALKER 215 B Farragut Court Apt. 205			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H3B! respiratory failure anemia										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET James / Spalding CITY OR TOWN 19 STATE 87						
22a. I certify that (1) (this hospital) examined the deceased from above, (2) we (did) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated.										
22b. SIGNATURE William Reese DEGREE MD					22c. DATE SIGNED 9/4/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) 12 Colgan, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 9-6-1987		23c. NAME OF CEMETERY OR CREMATORY JOHNSON GROVE CEMETERY		23d. LOCATION CITY OR TOWN Lawrenceville COUNTY Virginia STATE 87	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. ADDRESS Annapolis, Md. 21401					25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Rodgers			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. WALL			2a. DATE OF DEATH MONTH DAY YEAR 9/12/87		2b. HOUR 7:30 AM	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 9-6-19.13		
6. AGE (IN YEARS LAST BIRTHDAY) 74		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 987 Hillendale Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		
14. FATHER'S NAME Joseph		15. MOTHER'S MAIDEN NAME Rebecca Ashton		16. STREET ADDRESS / ZIP CODE 987 Hillendale Dr. 21401		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 562-12-3490		17. INFORMANT ADDRESS A. Ruth Wall (Same as above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End Stage Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>9 yrs</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/26</u> 19 <u>87</u> to <u>9/12</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Robert S. Barranco</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-1987		23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. MD		24. FUNERAL DIRECTOR NAME ADDRESS ROBERT S. BARRANCO SEVERNA PARK, MD. 21146				
25a. DATE REC'D. BY REGISTRAR SEP 18 1987				25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Lindner</u>		

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FILED

ROBERT S. BARRANCO
SEVERN PARK MD 21148

065528 SEP 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4972

1. DECEASED NAME (TYPE OR PRINT) W. A. Evelyn <i>W. A. Evelyn</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 2 1987</i>			2b. HOUR M <i>AM</i>				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR <i>12 26 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 159 O'Berry Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 159 O'Berry Court <i>21401</i>	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST GANTT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET QUEEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-1243		17. INFORMANT Annapolis, Md. 21401 JANICE BROOKS 159 O'Berry Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of uterine cervix</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>1. Asthma 2. H.D. Carcinoma of bladder 3. ?? Carcinoma of bladder</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/3</i> 19 <i>86</i> , to <i>9/1</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>7/3</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>ERROL A. Sullivan</i>					22c. DATE SIGNED <i>9/9/87</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERROL A. Sullivan			
22e. ADDRESS <i>1835 Forest Drive, Annapolis, Md.</i>					22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-9-1987		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland			
24. FUNERAL DIRECTOR Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.					25a. DATE REC'D. BY REGISTRAR SEP 14 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

082238 209 12 81



067164 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
STATE
REGISTRAR

REG. NO. 24973 EDT

1. DECEASED NAME (TYPE OR PRINT) HILDA REGINA WARFEL			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 26, 1987		2b. HOUR 0210 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Schultz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Chase		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No NA		16b. SOCIAL SECURITY NO. 220.07.1793	
17. INFORMANT (Husband) ADDRESS Charles G. Warfel, Sr. Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) Candida Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-21 , 19 87 , to 9-26 , 19 87 , that (I) (we) lost saw the deceased alive or above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward N. Sherman		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD N. SHERMAN, M.D.		22e. ADDRESS 95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.	
24. FUNERAL DIRECTOR NAME R. A. Shaker		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall	

BP

007101 20 92 02 07

CLIN. PHARM. NORTH AMER. HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items, , & 13e., G-632, 10/7/87, by the

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24974

067366 OCT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACK L. F. WERNER		20. DATE OF DEATH MONTH DAY YEAR 09 27 87		21. HOUR 12:20 P. M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY Retail Food
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Crofton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Adam F. Werner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Suthard		16. SOCIAL SECURITY NO. 216304366	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1958-1961		17. INFORMANT ADDRESS Allona Werner, Same as # 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerotic heart disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/16 19 87 , to 9/25 19 87 , that (I) (we) lost saw the deceased alive on 9/25/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE My Chomars		DEGREE		22c. DATE SIGNED 9/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Chomars		22e. ADDRESS 205 Ridgely Ave Annapolis MD		22f. DATE REC'D. BY REGISTRAR SEP 30 1987	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Lakemont Memorial	
23d. LOCATION (CITY OR TOWN) Davidsonville, Maryland		23e. COUNTY 21401		23f. STATE MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		24b. ADDRESS 16000 Annapolis Rd. Bowie, Maryland 20715		25. REGISTRAR'S SIGNATURE Julia Dandora-Randall	

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066576

SEP 23 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4375

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GROVER (NMN) WILLIS			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1987		2b. HOUR 300M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 10, 1923	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	12b. KIND OF BUSINESS OR INDUSTRY B&O Rail Road	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Homer Willis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Hicks		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Wife) Ruth V. Willis	ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b) Myopathic Neuropathy of Unknown Etiology 3 months
DUE TO, OR AS A CONSEQUENCE OF (c) Life Long Arthritis - Rheumatoid Arthritis 60 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 1987 to September 18 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 9/17/87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE ELLIOTT GORBATY		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORBATY, M.D.		22c. ADDRESS 7845 OADWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 21, 1987	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland		
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland	25a. DATE REC'D BY REGISTRAR SEP 22 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the funeral director must be notified at once.

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SEPTEMBER 19

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ANN ARBOR, MICH.

NORTH ARBOR HOSPITAL

CLINIC

RECEIVED
SEP 23 1912
NORTH ARBOR HOSPITAL

CLINIC, ANN ARBOR, MICH.
1812 JEFFERSON ROAD, SOUTH 202

RECEIVED

065382 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24276

1. DECEASED NAME (TYPE OR PRINT) Dorothy Elder Wood			2a. DATE OF DEATH MONTH DAY YEAR 9 9 87		2b. HOUR 1 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 20, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD			13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel S. Elder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Willis Small		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1. <u>2 prior episodes of MI & a stroke</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/26/87</u> 19 <u>87</u> to <u>9/9/87</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/26/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>[Signature]</u>		22c. DATE SIGNED 9/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS 1835 Bond Ave S. Rmd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD		25a. DATE REC'D. BY REGISTRAR SEP 10 1987			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rodgers			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065380 SEP 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24977

1. DECEASED NAME (Type or Print) DAPHNE MARQUERITE WRIGHT			2. DATE OF DEATH MONTH DAY YEAR Sept - 3 - 87		2b. HOUR P
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Jan. 11 1923	6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN ENGLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL		
10. CITY OR TOWN OF DEATH CROFTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) 1717 Tipton Drive		12a. USUAL OCCUPATION (Type or Print Work for Most of Working Life) PARA - Legal		12b. KIND OF BUSINESS OR INDUSTRY LAW
13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13a. STATE MD. 13b. COUNTY AA 13c. CITY OR TOWN CROFTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS Augustus HAWES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian ROSE LAYTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 379 46 6922	17. INFORMANT NAME ADDRESS COHN SANDERS WRIGHT #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minute 6 mo					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Intestinal Obstruction, ureteral obstruction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 13, 1987 to 9/3, 1987 , that (I) (we) lost sight of the deceased alive on 7/13 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William C. Weintraub		DEGREE MD 22c. ADDRESS 2568 A Gwa Rd. Annapolis, Md.		22d. DATE SIGNED 9/4/87	
22e. PHYSICIAN (Type or Print) WILLIAM C. WEINTRAUB		22f. ADDRESS 2568 A Gwa Rd. Annapolis, Md.		22g. DATE SIGNED 9/4/87	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 9/5/1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	
23d. LOCATION CITY OR TOWN Bethesda		23e. COUNTY P.G. MD.		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL		24b. ADDRESS Annapolis Md.		25a. DATE REC'D. BY REGISTRAR SEP 10 1987	
25b. REGISTRAR'S SIGNATURE Julia Sanders-Rudney					

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THE UNITED STATES OF AMERICA

TO THE HONORABLE

SENATE

AND HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

IN SENATE

SEPTEMBER 14, 1987

REPORT OF THE

COMMISSION ON THE

STATUS OF THE

AMERICAN INDIAN

POPULATION

AND THE

INDIAN LANDS

AND RESOURCES

IN THE

UNITED STATES

OF AMERICA

AND THE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The placard must have carbon papers, page 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
1. FOR STATE REGISTRAR		MAR4 E. CARTER		Fe		CAU		MAY 30 1914		73 YRS.		NY		U.S.A.				AA AA		Ft Meade Md		Kimbrough Army Hosp		Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																			
MARYLAND		ANNE ARUNDEL		SEVERN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		845 EVERGREEN RD 21144																			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a). (b). (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
FRANK		ALICE		NO		127-16-4253		Olga Rosenthal		Acute Respiratory Failure		10 min															
		Daniele						#3 Aragon Ave. Latham, N.Y.		COPD		20 years															
										Adenocarcinoma of Lung		9 months															
										Hypertension																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																							
		HOUR A.M. MONTH DAY YEAR																									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION																							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE																	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED																							
saw the deceased alive on		DEGREE		13 Sept 87																							
above, (the) (we) (d) (did not) view the body after death.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		13 Sept 87																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																									
STAMM, CARL		KAMH, Ft. Meade, Maryland																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																					
Burial		Sept. 19, 1987		St. Alphonsus Cemetery		Queensbury, N.Y.																					
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE																							
Ives-Pearson Funeral Home		2847 Wilson Blvd.		SEP 16 1987		Julia Anderson-Rudner																					
Arlington, Va. 22201																											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
GISTRAR

1. DECEASED NAME (TYPE OR PRINT) Virginia M Young		2a. DATE OF DEATH MONTH DAY YEAR Sept 17 1987		2b. HOUR MIN 5 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 19 1904		6. AGE (YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Milwaukee Wisconsin	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Deale Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 613 IRVIN AVE 20751		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Household
13a. STATE Florida	13b. COUNTY Collier	13c. CITY OR TOWN Naples	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Apt #111-2082 Gulf Breeze Blvd 33943
14. FATHER'S NAME FIRST MIDDLE LAST James Bert Modesitt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 155-36-8049		17. INFORMANT ADDRESS Gerald H Young Naples Florida	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest Minutes DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease years DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): arthritis, gout, cataracts, glaucoma					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED No surgery		19c. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) no accident	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/25/87 to 9/17/87 that (I) (we) last saw the deceased alive on 9/15/87 and that (I) (my hour) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE C. H. Wirth M.D.		DEGREE M.D.		22c. DATE SIGNED 9/17/87	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Wirth, M.D.		23b. ADDRESS Lothian, Md 20711			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/18/87		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md.		23e. DATE REC'D. BY REGISTRAR SEP 18 1987			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS Annapolis, Md.		25. REGISTRAR'S SIGNATURE Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and consistently filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-steps. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24 980

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Theresa Yut Fuchs										2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 9 18 87		2b. HOUR 1037			
3 SEX F		4 RACE Can		5 DATE OF BIRTH MONTH DAY YEAR 9 28 1944		6 AGE (IN YEARS) (LAST BIRTHDAY) YRS. 43		IF UNDER 1 YR. MONTHS DAYS 87		IF UNDER 24 HRS. HOURS MIN. 1037		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 19 87		2d. HOUR 1037	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK.				7b CITIZEN OF WHAT COUNTRY? UNK.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH AA			
10 CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK.				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7428 Hawkins Dr.					
14. FATHER'S NAME FIRST MIDDLE LAST UNK.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK.				16b. SOCIAL SECURITY NO. UNK.				17. INFORMANT ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. ASCVD (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE William P. Jones				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 9/19/87			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.d.				ADDRESS 695 America Crt. Davidsonville, Md 21035											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 9-24-87				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR SEP 28 1987				25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMULIN 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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